(30)

No. 93-1415-CFX
Status: GRANTED

Title: Hospital Association of New York State, Petitioner
v.
Travelers Insurance Company, et al.

Docketed:
March 9, 1994

Court: United States Court of Appeals for
the Second Circuit

Vide:
93-1408
93-1414

Counsel for petitioner: Sherrin,Jeffrey J.

Counsel for respondent: Murphy,Craig P., Stromberg,Clifford D., Considine,Eileen, Smith,M. Patricia, Bicks,Robert A., Iselin,Harold N.

SEE APPENDIX IN 93-1414.

Entry	Date	Note	Proceedings and Orders
1	Mar 9 1994	G	Petition for writ of certiorari filed.
2	Apr 7 1994		Brief of respondents Travelers Insurance Company, et al. in opposition filed. VIDED.
3	Apr 8 1994		Brief of respondents New York State Health Organization, et al. in opposition filed. VIDED.
4	Apr 13 1994		DISTRIBUTED. April 29, 1994 (Page 2)
5	Apr 19 1994		LODGING consisting of twelve copies of the decision in NY State Health Maintenance v. Curiale received from the petitioner.
6	Apr 21 1994	X	Reply brief of petitioner Hospital Association of New York State filed. VIDED.
7	May 2 1994	P	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
8	Sep 14 1994		Brief amicus curiae of United States filed. VIDED.
9	Sep 21 1994		REDISTRIBUTED. October 7, 1994 (Page 14)
10	Sep 27 1994	X	Supplemental brief of respondents filed. VIDED.
12	Oct 6 1994		Letter from the Solicitor General received and distributed.
13	Oct 7 1994		Petition GRANTED. limited to Question 1 presented by the petition. The brief of petitioners is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Wednesday, November 16, 1994. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 13, 1994. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Thursday, December 29, 1994. Rule 29.2 does not apply. **********
14	Nov 14 1994		SET FOR ARGUMENT WEDNESDAY, JANUARY 18, 1995. (1ST CASE)
19	Nov 15 1994		Brief amicus curiae of United States filed. VIDED.
20	Nov 15 1994		Brief amici curiae of Minnesota, et al. filed. VIDED.
15	Nov 16 1994		Joint appendix filed. VIDED.
16	Nov 16 1994		Brief of petitioners NY State Conference of Blue Cross & Blue Shield Plans, et al filed. VIDED.
17	Nov 16 1994		Brief of petitioner Hospital Association of New York State filed. VIDED.
18	Nov 16 1994		Brief of petitioners Mario M. Cuomo, et al. filed. VIDED.

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No. 93-1415-CFX

Entry	Date	Note	Proceedings and Orders
21	Nov 16 1994		Brief amici curiae of American Hospital Association, et al. filed. VIDED.
22	Nov 16 1994		Brief amicus curiae of American Federation of State County and Municipal Employees filed. VIDED.
23	Nov 16 1994		Brief amici curiae of National Governors' Asociation, et al. filed. VIDED.
24	Nov 18 1994		Record filed.
		*	Original record proceedings United States District Court for the Southern District of New York (2 BOXES)
25	Nov 23 1994	G	Motion of respondents New York State Health Maintenance Organization Conference, et al. for divided argument filed.
26	Nov 25 1994		CIRCULATED.
27	Nov 30 1994		Response filed by respondents Travelers Insurance Co., et al. to motion of respondents New York State Health, et al. for divided argument.
29	Dec 1 1994	G	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
28	Dec 5 1994		Motion of respondents New York State Health Maintenance Organization Conference, et al. for divided argument GRANTED. to be divided as follows: 20 minutes - Travelers Insurance Co., et al.; and 10 minutes - New York State Health Maintenance Organization Conference, et al.
31	Dec 12 1994		Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
34	Dec 12 1994	X	Brief amici curiae of Self-Insurance Institute of America, Inc. filed. VIDED.
32	Dec 13 1994	X	Brief of respondents NY State Health Maintenance Organization Conference filed. VIDED.
33	Dec 13 1994	X	Brief of respondents Travelers Insurance Company, et al. filed. VIDED.
35	Dec 13 1994	X	Brief of International Foundation of Employee Benefit Plans filed. VIDED.
36	Dec 13 1994	X	Brief amici curiae of NYSA-ILA Welfare Fund, et al. filed. VIDED.
37	Dec 13 1994	X	Brief amicus curiae of Group Health Association of America, Inc. filed. VIDED.
38	Dec 13 1994	X	Brief amici curiae of Trustees of and Pension Hospitalization Benefit Plan, et al. filed. VIDED.
39	Dec 13 1994	X	Brief amici curiae of Association of Private Pension and Welfare Plans, et al. filed. VIDED.
40	Dec 13 1994	X	Brief amicus curiae of National Carriers' Conference Committee filed. VIDED.
41	Dec 13 1994	X	Brief amicus curiae of National Coordinating Committee for Multiemployer Plans filed. VIDED.
45	Dec 22 1994	G	Motion of Federation of American Health Systems for leave to file a brief as amicus curiae filed.
42	Dec 29 1994	X	Reply brief of petitioners Mario M. Cuomo, et al. filed.

No. 93-1415-CFX

Entry	Date	Note	Proceedings and Orders
			VIDED.
43	Dec 29 1994	X	Reply brief of petitioner Hospital Association of New York State filed. VIDED.
44	Dec 29 1994	X	Reply brief of petitioners NY State Conference of Blue Cross & Blue Shield Plans, et al filed. VIDED.
46	Jan 17 1995		Motion of Federation of American Health Systems for leave to file a brief as amicus curiae GRANTED.
47	Jan 18 1995		ARGUED.

FILED

(1)

No. —— 931415 MAR 9 1994

OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

v.

THE TRAVELERS INSURANCE COMPANY, HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIAN'S HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts New York's all-payor hospital reimbursement system to the extent that the system provides, irrespective of ERISA status, one set of rates for patients covered by Medicaid, Blue Cross plans and health maintenance organizations ("HMOs") and another set of rates for patients covered by other third-party payors, including commercial insurers and self-insurerd plans, because different costs may be experienced by ERISA plans based on their choice of coverage.

2. Whether the Federal Employees Health Benefits Act ("FEHBA") preempts New York's all-payor hospital reimbursement system to the extent that the system provides, irrespective of FEHBA, one set of rates for patients covered by Medicaid, Blue Cross plans and HMOs and another set of rates for patients covered by other third party payors.

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the decision of the United States Court of Appeals for the Second Circuit, which is contained in the separately bound joint appendix at pages A-1 to A-2. Because of the numerosity of the parties, the list will not be reproduced herein.

In accordance with the Supreme Court Rule 29.1, Petitioner Hospital Association of New York State states that it does not have a corporate parent or subsidiaries, other than wholly-owned subsidiaries.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. _____

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

v.

THE TRAVELERS INSURANCE COMPANY, HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIAN'S HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Hospital Association of New York State ("HANYS") respectfully petitions this Court for a writ

of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The amended opinion of the Court of Appeals for the Second Circuit is not reported. It is reproduced in the separately-bound joint appendix at A-1 to A-34. The decision of the United States District Court for the Southern District of New York is reported at 813 F. Supp. 996 (S.D.N.Y. 1993). It is also reproduced in the appendix at A-63 to A-90.

JURISDICTION

The judgment of the Court of Appeals was initially entered on October 25, 1993. On January 12, 1994, the Court of Appeals granted a petiiton for a rehearing, and on January 14, 1994, the Court of Appeals entered an amended opinion. Pursuant to Rule 13 of the Rules of the Supreme Court of the United States, this petition is filed within ninety (90) days of the date of the amended opinion. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (1988).

STATUTORY PROVISIONS INVOLVED

1. The relevant statutory provisions are:

(a) ERISA § 514(a), (codified at 29 U.S.C. § 1144(a) (1988)), which provides that:

> Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III of this Chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Pub. L. No. 101-508, § 7002(c), 104 Stat. 1388-330 (1990), (codified at 5 U.S.C. § 8909 (f)(1) (Supp. IV 1992)) which provides:

Exemption From State Premium Taxes—Section 8909 of title 5, United States Code, is amended by adding at the end the following:

> (f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(c) N.Y. PUB. HEALTH LAW § 2807-c(1)(a) (McKinney 1993), a copy of which is set forth in the appendix at A-101 to A-102.

(d) N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993), a copy of which is set forth in the appendix at A-102 to A-103.

STATEMENT OF THE CASE

This action involves a challenge under the Employee Retirement Income Security Act of 1974 ("ERISA") and the Federal Employees Health Benefit Act ("FEHBA") by several commercial insurance companies and their trade associations to the statutory method by which New York State controls inpatient hospital rates for all patients. The Court of Appeals below held that these federal statutes perempted a New York law that created one set of hospital rates for patients covered by Blue Cross, HMOs, and Medicaid, and another (higher) set of rates for patients covered by other arrangements, even though the Court recognized that plans subject to ERISA and FEHBA (like any other consumer) are free to choose either category of coverage. The Court thought it sufficient for preemption under ERISA that the law "purposely interfere[s] with the choices that ERISA plans make for health care coverage," A-22, and that (for plans electing certain kinds of coverage) the law "substantially increase[s] the

cost to ERISA plans of providing beneficiaries with a given level of health care benefits." A-23. It justified preemption under FEHBA on the ground that the differential between the rates charged for hospital services was an impermissible "tax, fee, or other monetary payment . . . with respect to any payment made from the [Federal Employees Health Benefits] Fund." 5 U.S.C. § 8909(f)(1) (Supp. IV 1992).

A. New York's Hospital Reimbursement System

1. *The Overall System*

As part of its effort to assure access to quality health care services (*see* N.Y. COMP. CODES R. & REGS. tit. 10, Part 405 (1993)), and to control health care costs, New York State regulates the rates for in-patient hospital care rendered to all patients, other than those covered by Medicare.[1] N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993). Under the current rate-setting system, medical procedures are divided into categories known as diagnostic related groups ("DRGs"), based on a patient's medical diagnosis. Each DRG category is then assigned a different "case based" rate which, as described below, depends on numerous factors. The theory behind these case based rates is that paying hospitals a fixed amount per condition gives them an incentive to control costs and to use their resources efficiently.

While the DRG categories are the same for all hospitals, the actual case based rate for each diagnosis varies from hospital to hospital. The reason is that the particular amounts for each hospital reflect a multitude of factors that are hospital-specific. Those factors include a

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[1] Since Medicare is strictly a federal program, individual states may not set Medicare rates unless they have obtained an express authorization from the United States Department of Health and Human Services. Such an authorization was previously in effect and, between 1985 and 1988, Medicare participated in New York's "all-payor" system.

hospital's historical operating costs, its capital costs, the total number of patients it treats annually, the total number of Medicare patients it treats annually, whether the hospital is a teaching facility, whether the hospital is located in New York City or upstate, and whether the hospital is situated in a rural community.

2. *The 13% Differential*

(i) *Generally*

The DRG categories are the basis for the final case based rates, which are arrived at by computing adjustments to reflect a myriad of hospital-specific factors. New York Public Health Law section 2807-c(1)(a) requires hospitals to bill patients covered by Medicaid, Blue Cross plans and HMOs at the hospital's case based rate. In contrast, New York Public Health Law section 2807-c(1)(b) requires hospitals to bill patients covered by workers' compensation, commercial insurance, the volunteer firefighters' benefit system, the volunteer ambulance workers' system, self-insured plans and the "no-fault" motor vehicle insurance system a different case based rate which is 113% of the Medicaid-Blue Cross-HMO rate.[2] It is this 113% multiplier—which effectively creates a 13% differential between the two sets of rates—that Respondents have sought to invalidate.[3]

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[2] There are patients who do not fall within either of these provisions. For example, patients who are not covered by insurance or who are covered by self-insured funds that do not make direct payments to hospitals fall into a third category under New York Public Health Law section 2807-c(1)(c), and are billed charges for hospital services. Such charges, however, may not exceed approximately 131% of the case based rate that would apply if the patient were subject to section 2807-c(1)(a).

[3] Respondents, commercial insurers and their trade associations, have also challenged a recently-enacted 11% assessment imposed on hospital bills for those patients covered by commercial insurance. 1992 N.Y. Laws ch. 55, § 348. In addition, some of the commercial insurer Respondents as well as the HMO Respondents have challenged a 9% assessment, enacted by the same section, which is

(ii) *History*

The current 13% differential in hospital rates evolved from 14 years of legislation designed to spread the burdens of financing in-patient hospital care fairly among the many payors in the system. Prior to 1978, with the exception of certain mandatory rates applicable to Medicaid and Blue Cross that were based upon a hospital's historical costs, there were no limits on what hospitals could charge patients. The result was that hospital rates were widely disparate with no incentive toward efficiency or cost controls.[4] Accordingly, the State enacted temporary cost containment legislation in 1978 that froze hospital charges to commercially insured patients until a more comprehensive approach was developed.

In 1982, the State enacted its first comprehensive hospital reimbursement statute, called the New York Prospective Hospital Reimbursement Methodology ("NYPHRM I"). That statute included a provision prohibiting hospitals from charging patients more than 12% to 25% above the cost-based rates that applied to Medicaid and Blue Cross plans. These cost controls applied to hospital rates for all patients, including those covered by the federal Medicare program. Recognizing the effectiveness of state regulation in containing health care costs, Congress authorized the Secretary of Health and Human Services to elect Medicare participation in state programs, which the Secretary did with respect to NYPHRM I. 42 U.S.C. § 1395b-1 (1988). Indeed, when Congress substantially reformed Medicare into a prospective rate-setting system in 1983, it reaffirmed the importance of Medicare partici-

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imposed on hospital bills for patients covered by HMOs. HANYS takes no position on the 11% and 9% assessments as they are not used to meet the costs that hospitals must incur. Rather, they are a means to raise revenue for the State. Neither the 11% assessment nor the 9% assessment applies to self-insured funds.

[4] During the mid-1970's, for instance, hospitals' bills for patients covered by commercial insurance were anywhere from 13% to 36% more than bills for patients covered by Medicaid and Blue Cross.

pation in NYPHRM I's system, in particular. *See generally Rebaldo v. Cuomo,* 749 F.2d 133, 136 (2d Cir. 1984), *cert. denied,* 472 U.S. 1008 (1985).

In 1985, NYPHRM I expired and NYPHRM II was enacted, covering in-patient hospital reimbursement from 1986 through 1987. NYPHRM II provided that the difference between cost-based rates and other rates could not exceed 12%.

In 1988, the State enacted NYPHRM III, which governed hospital reimbursement from 1988 through 1990. NYPHRM III changed the reimbursement methodology from a dual charge-based/cost-based system to a single all-payor case payment system, with a 13% differential between the rates for patients covered by Medicaid, Blue Cross and HMOs, and those covered by other third-party payors. In 1990, the State enacted NYPHRM IV, which governed hospital reimbursement from 1991 through 1993. NYPHRM IV continued the all-payor case payment system, including the 13% differential.

The change from a partial cost-based system to an all-payor case payment system was consistent with congressional initiatives toward state regulation of health care costs. At the time Congress was considering changing Medicare into a prospective rate system, it was also encouraging state Medicaid programs, including New York's, to consider abandoning cost-based reimbursement in favor of prospective systems.[5] In addition, realizing that hospitals could shift costs to non-governmental payors in the case of a partial cost-based system, Congress encouraged states to develop all-payor systems.[6] Congress was also

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[5] *See* H.R. REP. No. 158, 97th Cong., 1st Sess., pt. 2, at 293 (1981) ("The Committee is especially interested in the development of prospective rate methodologies as a replacement for the current reasonable cost reimbursement system under Medicaid").

[6] *See, e.g., Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Finance Comm.,* 98th Cong., 1st Sess., pt. 1 at 148 (1983) (Statement of Robert M.

aware that an all-payor system does not mean that all rates must be the same; rather, the system may be structured such that rates may differ among payors.[7]

The rates established by the New York Public Health Law operate without regard to whether the patient is or is not an ERISA plan beneficiary. Neither section 2807-c(1)(a) nor section 2807-c(1)(b) makes any reference

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Crane, N.Y. State Dep't of Health ("[A]n effective cost containment program requires all payers to participate. Otherwise, the primary effect is simply cost-shifting among third-party payers"), and at 209 (Sen. Durenberger) ("In the absence of an all payer-system you don't get that cost-sensitivity because the costs are shifted"); STAFF OF SENATE SPECIAL COMM. ON AGING, 98TH CONG., 1ST SESS., CURRENT DEVELOPMENTS IN PROPECTIVE REIMBURSEMENT SYSTEM FOR FINANCING HOSPITAL CARE (Comm. Print 1983) ("[A]ll-payer systems . . . will have a more significant impact on hospital expenditures . . . because the greater the proportion of hospital revenues controlled, the more the cost-containment potential of the prospective system is increased."); *Administration of Medicare Cost-Saving Experiments: Hearings Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 94th Cong., 2d Sess. 27 (1976) (Statement of Elmer W. Smith, Social Security Administration) ("[P]rospective payment systems will not be fully viable unless they include all payers. This means that whenever possible we are encouraging and participating in prospective payment systems that include other third-party payers such as Medicaid, Blue Cross and commercial insurers").

[7] This congressional recognition is established by a 1987 report to Congress by Otis R. Bowen, M.D., then Secretary of Health and Human Services. (Otis R. Bowen, M.D., Department of Health and Human Services, *Report to Congress: The Relationship of Medicare PPS to All Payer Systems and Cost-Shifting*, No. 87-1, at II-47 to III-11 (Jan. 1987)).

> "In establishing rates for all payers, States must decide whether to emphasize equity and establish one rate for all payers or to allow discounts. . ." (*Id.* II-47)
>
> "An important decision in the development of an all-payer system is whether to establish the same rates for all payers or to set a maximum price and allow discounts to be granted in certain cases. Discounts might be granted . . . to reflect charge discounts historically received by certain payers (e.g. BC, Medicaid)" (*Id.* II-53-54).

whatsoever to ERISA plans. Nor does the applicable rate there established depend on ERISA status. Under the system, a hospital will bill a patient covered by Blue Cross the prescribed case payment rate, regardless of whether that patient participates in an ERISA plan. Similarly, a hospital will bill a patient covered by a workers' compensation fund 113% of that case-payment rate, even though such fund is not covered by ERISA.

In addition, the challenged New York statute does not restrict any choice that an ERISA plan may have as to form of coverage—self-insured, commercially insured or Blue Cross. It also does not restrict a plan from choosing to cover, in whole or in part, particular kinds of benefits.

B. Decisions Below

1. *District Court*

Respondent The Travelers Insurance Company initially commenced a civil action against the State defendants seeking, *inter alia*, a declaratory judgment invalidating the 13% differential under ERISA. This was followed by a second action brought by Respondent the Health Insurance Association of America and other insurance trade associations and individual insurance companies also seeking, *inter alia*, a declaratory judgment invalidating the 13% differential under ERISA, as well as under FEHBA. HANYS, the New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively referred to herein as "Blue Cross") intervened in both actions as defendants. The New York State HMO Conference and Health Services Medical Corporation and eleven individual HMOs then intervened in both actions as plaintiffs. The District Court subsequently consolidated the two actions.[8]

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[8] The District Court's jurisdiction was based on 28 U.S.C. § 1331 (1988).

On February 3, 1993, the District Court granted summary judgment in favor of Respondents, and enjoined the State of New York from enforcing the 13% differential against any commercial insurer or HMO in connection with its coverage of an ERISA plan, or any insurer participating in the FEHBA program. In holding that the 13% differential "relates to" ERISA plans within the meaning of ERISA's preemption provision, the District Court found that the differential imposes a significant economic burden on commercial insurers which provide services to ERISA plans. 813 F. Supp. at 1003. According to the District Court, at least part of this economic burden is then passed on to ERISA plans that have purchased commercial insurance coverage, thereby affecting the structure and/or administration of such plans.[9] *Id.* at 1004-05.

The District Court also held that the 13% differential "relates to" ERISA plans because it diverts ERISA plan resources to a state-specified use which is unrelated to the health care of plan participants. *Id.* at 1004-05. In addition, the District Court concluded that because other hospital rates in other states may not include this cost, the statute creates inconsistent obligations upon multi-state ERISA plans.[10] *Id.* at 1004-05.

With respect to FEHBA, the District Court found that it was unclear under the statute as to whether FEHBA preempts all "taxes, fees or other monetary payments"

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[9] The purported economic cost of the 13% differential to commercial insurers and ERISA plans was vigorously disputed by the parties. This is particularly the case where insured plans pay insurance premiums, not hospital rates. Thus, what effect the 113% multiplier has on premiums is a function of the insurance contract, not the state law. Nevertheless, the District Court made these factual findings, without the benefit of discovery or trial, on a motion for summary judgment.

[10] In addition, the District Court ruled that the 13% differential did not fall within the scope of ERISA's "savings clause," which exempts from preemption state insurance laws. 813 F. Supp. at 1006-08.

that are imposed, directly or indirectly, on a carrier participating in the FEHBA program, or only those taxes, fees or monetary payments imposed on the "premiums" of such carriers. Due to this ambiguity, the District Court deferred to two identical opinion letters issued to the New York State Departments of Health and Insurance by the United States Office of Personnel Management ("OPM"), the agency that administers FEHBA. Although these letters did not specifically address preemption of the 13% differential—dealing only with the more recent 11% assessment—the Court found the letters authoritative with respect to both. The Court also deferred to an amicus brief submitted on behalf of OPM, which did address the 13% differential. *Id.* at 1009-11.

2. *Court of Appeals*

On January 14, 1994, the Second Circuit issued an amended opinion affirming the District Court's holding that ERISA preempts the 13% differential.[11] In ruling that the 13% differential "relates to" ERISA plans, the Second Circuit found that while the challenged statutes did not refer to ERISA plans, they satisfied "the less stringent 'connection with' standard" set forth in *Ingersoll Rand Co. v. McClendon*, 498 U.S. 133 (1990). A-22. The Court reasoned that the 13% differential "purposely interfere[s] with the choices that ERISA plans make for health care coverage" by making Blue Cross coverage more competitive than other health care coverage. *Id.*

The Second Circuit also stated that the 13% differential substantially increases the cost to ERISA plans of

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[11] On October 25, 1993, the Second Circuit issued its opinion affirming the District Court's holding that ERISA preempts the 13% differential. The Second Circuit's decision did not address the District Court's FEHBA holding. On or about November 5, 1993, HANYS and the other Petitioners petitioned the Second Circuit for a rehearing with a suggestion for a rehearing *en banc*. Those petitions resulted in the amended opinion.

providing beneficiaries with a given level of benefits, thus forcing ERISA plans either to increase plan costs or to reduce plan benefits. A-23. In response to Petitioners' contentions that the Supreme Court has never held that an indirect economic impact alone is sufficient to justify preemption, the Second Circuit cited a Southern District of New York decision, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146 (S.D.N.Y. Feb. 23, 1993) for the proposition that a substantial economic impact, standing alone, could be enough to cause preemption. A-24.

On the challenge under FEHBA, the Circuit Court ruled that FEHBA's preemption provision was not limited to State premium taxes. Instead, according to the Court, the provision applies to a monetary payment imposed on a carrier with respect to any payment from the FEHBA fund. Since the Circuit Court held that the 13% differential constituted a monetary payment imposed on such a carrier, it held that the 13% differential was also preempted under FEHBA. A-12 to A-17.

Following the Second Circuit's amended opinion, HANYS, the State and Blue Cross each moved the Court for a stay of its mandate pending application for a writ of certiorari. On February 7, 1994, the Circuit Court granted these respective motions.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

This decision warrants review for several reasons. First, insofar as the Second Circuit found preemption under ERISA, it put itself in direct conflict with a decision of the Third Circuit, holding that a virtually identical provision of New Jersey law was not preempted by ERISA. *See United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382, 383, *reh'g denied*, 114 S. Ct. 651 (1993). In rejecting the challenge, the Third Circuit held that ERISA did not preempt "a statute of general applicability that is designed to establish the prices to be paid for hospital services which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans." *Id.* at 1193. The Second Circuit expressly "decline[d] to follow" this reasoning. A-24 n.3.

Second, these issues are of considerable importance. New York is now barred from exercising the regulatory authority allowed to neighboring New Jersey. Furthermore, all states are in the quandary of not knowing whether—or in what manner—they can carry out traditional police powers of regulating hospital services and controlling health care costs. The result also seriously impedes federal cost-containment objectives.

Third, the Second Circuit's decision expands preemption beyond reasonable bounds. The New York law is indisputably a law of general application that makes no distinctions whatsoever with respect to ERISA plans. To the extent that ERISA plans may have an incentive to choose a particular form of coverage (*e.g.*, Blue Cross), they stand in exactly the same footing as everyone else. The New York law thus "relates to" ERISA plans—in the words of the ERISA preemption provision—only in the sense that *any* general law regulating rates "relates to" a

plan: that is, by subjecting the plan to burdens and benefits like others similarly situated. That has not been, and should not be, grounds for preemption of state law. *See Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988). The decision below, however, is now being interpreted as finding that economic impact, alone, is sufficient for ERISA preemption (*see New England Health Care Employees v. Mount Sinai Hosp.*, 2:92-CV-1012 (JAC) (D. Conn. Feb. 25, 1994)).[12]

Finally, the Second Circuit was mistaken in finding preemption under FEHBA. A hospital rate established pursuant to state law is not a "tax, fee, or other monetary payment . . . with respect to any payment made from the Fund"; rather, it is, like many other charges, simply a basis for calculating the proper charge for a service covered by the Fund. This natural reading of the statutory language is confirmed by the legislative history, which demonstrates quite clearly that Congress intended to preempt imposition of state premium taxes, in whatever form, but not to bar states from subjecting programs to generally applicable rates. The holding below to the contrary, like the holding finding preemption under ERISA, thus erects a wholly unwarranted barrier to the ability of states to subject all consumers of hospital services to important regulatory controls.

I. THERE IS A DIRECT CONFLICT BETWEEN TWO CIRCUIT COURTS WITH RESPECT TO AN ISSUE OF CONSIDERABLE IMPORTANCE

A. Conflict Between Two Circuit Courts

The decision of the Second Circuit in this action is in direct conflict with the Third Circuit's decision in *United Wire, supra.* While the Second Circuit held that ERISA preempts the 13% differential under New York's hospital

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[12] For the Court's convenience, twelve (12) copies of the *New England Health Care Employees* slip opinion have been lodged with the Clerk of the Court.

reimbursement system, the Third Circuit held that ERISA did not preempt a 13.2% differential under New Jersey's hospital reimbursement system. For all intents and purposes, the 13% differential under New York law is indistinguishable from the differential under New Jersey law, given that they both represent the spread between the hospital rates paid by certain high-volume payors, such as Blue Cross, which provide open enrollment policies, and those paid by other payors. The results in the two cases are thus irreconcilable.

Essentially, the two Courts reached these conflicting results due to diametrically opposed analyses of the significance under ERISA of an economic impact upon ERISA plans. The Second Circuit held that the 13% differential "relates to" ERISA plans because it purposefully imposes an economic impact on ERISA plans that have coverage other than Blue Cross. A-23. According to the Court, this economic impact, in turn, impermissibly forces ERISA plans "to increase either plan costs or [sic] reduce plan benefits." *Id.*

The Third Circuit, in contrast, held that the cost of the differential to ERISA plans under New Jersey law was irrelevant because an indirect economic impact, alone, is insufficient to justify preemption. The Third Circuit reasoned that the differential's economic impact was no different from a variety of state regulations that increase the cost of goods and services that hospitals consume and pass on in hospital costs, such as utility costs, wages and waste disposal costs. 995 F.2d at 1193. Under that analysis, the significant issue for the Third Circuit was not the amount of indirect costs imposed by the New Jersey law, but whether that law encroached on the affairs of ERISA plans in any concrete manner. And, in that respect, the Third Circuit concluded that:

> New Jersey's scheme [did] not direct ERISA plans to structure their benefits or conduct their internal

> affairs in any particular way. Nor [did] it deprive ERISA plans of any alternative they would otherwise have in these areas.

Id.[13]

The Second Circuit noted the Third Circuit's decision, but expressly stated that it "reads ERISA's preemption clause too narrowly" and declined to follow it. *Id.*[14]

B. Issues of Considerable Importance

The issue that divides the Second and Third Circuits is of great significance to a state's ability to exercise a fundamental state police power—the regulation of health care and the control of its costs. *See, e.g., Hillsborough County v. Automated Medical Lab, Inc.*, 471 U.S. 707, 719 (1985) ("the regulation of health and safety matters is primarily, and historically, a matter of local concern").

Pursuant to its traditional police powers as well as a constitutional mandate to protect and promote the health of the inhabitants of New York, the State has enacted laws designed to foster a fair and efficient health care delivery system. *See, e.g.*, N.Y. CONST. Art. XVII, § 3; *People ex rel. Whalen v. Woman's Christian Ass'n*, 377 N.E.2d 725, 727-28 (N.Y. 1978) ("There is no question that the economic regulation of hospital costs . . . ad-

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[13] The Third Circuit also suggested that the plaintiffs' position in *United Wire* was contradictory because it selectively challenged certain components of New Jersey's hospital reimbursement system, but accepted other components of the state rate-setting scheme which also impose an economic impact on ERISA plans. *United Wire*, 955 F.2d at 1196. The Second Circuit did not address this contradiction.

[14] The most recent decision in this area, *New England Health Care Employees, supra*, read the Second Circuit's decision as holding that the differentials relate to ERISA plans, and are preempted, soley because they impose a significant economic burden on plans. Accordingly, the Connecticut district court was bound to reject the Third Circuit's view in *United Wire*, and did so.

vanced the legitimate legislative purposes of promoting health, welfare and safety, all consonant with Section 3 of Article XVII of our state Constitution." As inflationary pressures threatened to compromise this important purpose, New York enacted in 1982 comprehensive legislation to regulate hospital costs. Since that time, the State has developed, with federal approval, an all-payor hospital reimbursement system that seeks to provide hospitals with necessary financial resources while containing costs and spreading them equitably among all payors. This action now threatens New York's ability to achieve these balanced objectives.[15]

Aside from paralyzing New York's efforts to contain spiraling health care costs, the Second Circuit decision will paralyze such efforts of every other state, as well as the federal initiatives that have served as the catalyst for these rate-setting systems. Should a state continue to regulate hospital rates in any form, that state and its hospitals not only face certain litigation, they also face potentially crippling liability.[16] In this regard, commer-

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[15] Indeed, the District Court acknowledged that its holding may mean that New York is prohibited from enacting *any* kind of comprehensive regulation controlling hospital costs. Specifically, the Court stated that:

> Defendants correctly note that to the extent that the Court finds that New York's statutes "relate to" employee benefits plans, then "ERISA preempts all state hospital rate-setting statutes, at least to the extent they apply to rates charged to patients that are paricipants in ERISA plans which include hospital expenses as a benefit." (Defendants' Brief at 25 n.19). This result is obviously undesirable in that it greatly complicates states' efforts to regulate and control hospital costs.

813 F. Supp. at 1006.

[16] In *Capo et al. v. HANYS et al.*, No. 93 Civ. 7996 (S.D.N.Y.), an ERISA plan has used the Second Circuit's judgment as the basis of a class action suit brought on behalf of all employee benefit plans against a class of all general hospitals in New York State seeking to recover all sums paid since 1988 attributable to the 13% differential. The total amount paid by all payors with respect to the differentials since 1988 is a sum estimated to exceed $1.5 billion.

cial insurers and ERISA plans already have construed the Second Circuit's decision as providing them with immunity from any State control of hospital rates. Following the District Court's decision in this action, commercial insurance companies and ERISA plans have brought a litany of ERISA actions seeking to invalidate various other components of state hospital reimbursement systems. *E.g., New England Health Care Employees, et al. v. Mount Sinai Hosp., et al.*, No. 2:92-CV 1012 (JAC) (D. Conn.) (Feb. 25, 1994) (challenging Connecticut's uncompensated care pool)[17]; *Connecticut Gen. Life Ins. Co. et al. v. Cuomo*, No. 93-3648 (S.D.N.Y.) (challenging New York's balance billing law); *Boyle et al. v. Anderson*, No. 3-93-359 (D. Minn.) (challenging Minnesota's methodology of funding care to the uninsured and under-insured); and *Trustees of & the Pension Hospitalization Benefit Plan et al. v. Cuomo et al.*, 92 Civ. 5589 (E.D.N.Y.) (challenging New York's funding of bad debt and charity care).

In addition to precluding a state's ability to achieve its own traditional police power objectives, the Second Circuit decision will impede federal cost-containment policies. For more than a decade, Congress has been encouraging states to enact comprehensive all-payor hospital cost containment legislation. The federal Medicare Act specifically provides that the Secretary of Health and Human Services may elect to reimburse hospitals under Medicare pursuant to comprehensive reimbursement sys-

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[17] In *New England Health Care Employees, supra*, the Connecticut district court, relying in large part on the Second Circuit's ruling, held that ERISA preempts a Connecticut statute designed to compensate hospitals for the cost of providing services to Connecticut's indigent, uninsured and underinsured. That statute required hospitals to include an assessment in their bills to defray the costs of uncompensated care. Citing the Second Circuit's decision, the district court ruled that the economic impact of the Connecticut law on ERISA plans was sufficient to warrant preemption.

tems.[18] Thus, to the extent the Second Circuit's decision interferes with a state's authority to develop an all-payor hospital reimbursement system, it runs contrary to federal cost containment policies.

Finally, the Second Circuit decision gives rise to the broader issue regarding the extent to which states can enact any law regulating the operation of hospitals and other health providers. The Third Circuit in *United Wire* suggested that if the differential in that case were invalidated due to its indirect economic impact, then a host of other state health laws may be preempted because they have some indirect impact on hospital costs. The Third Circuit observed, for example, that state regulation of medical waste disposal would be preempted because it significantly increases a hospital's cost of doing business and, accordingly, its billings to plan participants. *United Wire*, 993 F.2d at 1193. Under the same rationale, laws providing minimum staffing levels for physicians and nurses, record-keeping requirements, construction codes and infection control procedures could also be preempted. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 10, Part 405 (1993). Without clear guidance from this Court, this action will likely spawn challenges to these and other fundamental state health laws, seeking to immunize ERISA plans from any costs associated with those laws.

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[18] *See, e.g.*, 42 U.S.C. § 1395f(b)(3) (1988), which authorizes the Secretary to continue to reimburse hospitals pursuant to a previously approved demonstration reimbursement system until the Secretary determines that "a third-party payor reimburses such a hospital other than under such system. . . ." *See also* 42 U.S.C. § 1395ww(c) (1988), which expands the Secretary's authority to participate in state reimbursement systems beyond a limited demonstration or experimental program, provided the state system reviews "at least 75 percent" of all inpatient revenue. This necessarily envisions state control over all private insurers' rates.

II. THE SECOND CIRCUIT EXPANDED THE SCOPE OF ERISA PREEMPTION

This case represents the first time a Circuit Court decision can be read to hold that ERISA preempts a law of general application simply because it has an indirect economic impact on ERISA plans. If this interpretation is sustained, ERISA plans will lead a "charmed existence that was never contemplated by Congress." *United Wire*, 995 F.2d at 1194, *quoting Rebaldo*, 749 F.2d at 138-39.

New York Public Health Law sections 2807-c(1)(a) and 2807-c(1)(b), the two provisions which create the 13% differential, neither refer nor specifically apply to ERISA plans. To the contrary, these provisions apply to hospital bills of patients covered by third-party payors, irrespective of ERISA status. Section 2807-c(1)(a), for example, requires hospitals to bill patients covered by Blue Cross or an HMO at the case based applicable rate, regardless of whether that coverage is furnished through an ERISA plan. Similarly, section 2807-c(1)(b) requires hospitals to bill patients covered by commercial insurance 113% of the applicable case based rate, whether or not that insurance is purchased by an ERISA plan. In addition, section 2807-c(1)(b) requires hospitals to bill patients covered by, among others, workers' compensation funds and no fault insurance, which are not covered by ERISA, the same rate as patients covered by a self-insured fund, which may be covered by ERISA.[19]

It is significant that these provisions speak to hospital rates for patients, and not to ERISA benefits for ERISA plan participants and beneficiaries. The provisions do not restrict an ERISA plan from determining its form or level of benefits. ERISA plans are free to self-insure,

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[19] Further, hospitals bill patients covered by ERISA self-insured funds that do not make direct payments to hospitals on the basis of charges (i.e. prices) under section 2807-c(1)(c), instead of a case based rate. Thus, patients covered by ERISA plans may fall into any of the three provisions under New York law.

join an HMO, insure through commercial insurance or insure through Blue Cross. And, regardless of the funding method, an ERISA plan is free to determine whether it will cover some, all or none of a participant's medical expenses.

At most, the New York law has an indirect economic impact that affects ERISA plans in the same manner as it affects other consumers and providers of health insurance. This indirect impact is simply insufficient to justify preemption. Otherwise, ERISA plans would be exempt from any state regulation that indirectly affects the cost of doing business, including rent control laws, labor laws and highway tolls.

As recognized by the Third Circuit in *United Wire*, this Court already has rejected such an expansive approach to ERISA preemption. In *Mackey*, this Court ruled that ERISA did not preempt the application of a state garnishment statute to ERISA plans even though it created substantial costs to such plans. This finding is wholly in accord with this Court's long-standing principle that ERISA does not preempt state laws that have "only a 'tenuous, remote, or peripheral' connection with covered plans . . . as is the case with many laws of general application." *District of Columbia v. Greater Wash. Bd. of Trade*, —— U.S. ——, 113 S. Ct. 580, 583 n.1 (1992), *quoting Shaw v. Delta Air Lines*, 463 U.S. 85, 100 n. 21 (1983).

In addition, the Second Circuit failed to consider whether Congress intended for ERISA to preempt generally-applicable state hospital laws, in particular. This is contrary to a line of Supreme Court cases that establish Congressional intent as the "ultimate touchstone" in any preemption analysis. *E.g., Cipollone v. Liggett Group*, 112 S. Ct. 2608, 2617 (1992), *quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978). This line of cases applies the preemption doctrine cautiously in order to prevent federal laws from encroaching onto

traditional state police powers, absent compelling evidence of Congressional intent. *E.g., Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (preemption analysis "start[s] with the assumption that the historic police powers of the States [are] not to be superseded . . . unless that [is] the clear and manifest purpose of Congress"); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981) (the need for unmistakable Congressional intent is "guided by respect for separate spheres of governmental authority preserved in our federalist system").

Given these cases, this decision cannot stand. In determining whether Congress intended to preempt state regulation of health care costs and charges, it is necessary to examine what Congress has said, and legislated, on both employee benefits and health care. *United Wire* undertook such a dual analysis; the decision below did not. While paying heed to Congress' intent to broadly preempt state laws under ERISA, the Second Circuit simply ignored twenty-five years of Congressional legislation and encouragement of state efforts to regulate hospital costs and the development of all-payor reimbursement systems to equitably apportion those costs.

III. THE SECOND CIRCUIT WRONGLY CONCLUDED THAT FEHBA PREEMPTS NEW YORK LAW

The Second Circuit's finding of preemption under FEHBA suffers from the same faulty reasoning employed in its ERISA analysis, i.e., a presumption that a state rate-setting statute of general application is preempted because a component of that rate has an economic impact upon plans. Thus, the same considerations, other than conflict among circuits, that compel granting of the writ of certiorari for ERISA preemption issues apply for the FEHBA issue. The uncertainty created by the Second Circuit's ruling on FEHBA is appropriate for resolution by this Court. For the following reasons, that ruling is also erroneous.

FEHBA does not preempt a state law of general application that regulates hospital rates. FEHBA section 8909(f)(1) prohibits any tax, fee or monetary payment imposed with respect to any payment from the FEHB Fund; it does not preempt a payment from the Fund itself. New York Public Health Law sections 2807-c (1)(a) and 2807-c(1)(b) merely determine the amounts that hospitals must bill patients for their services. The 113% multiplier is not a tax on the payment of the bill, it is one step in the calculation of what that bill will be. Thus, these provisions simply set the rates upon which the Fund determines what it will pay for hospital services, and they do not constitute any extra fee, tax or monetary payment on such rates.

Moreover, FEHBA's legislative history and regulations indicate that the statute preempts only state premium taxes. The House Report to the FEHBA bill stated that "[i]n order to meet the savings targets charged to the Committee, the legislative language exempts the [FEHBA Program] from *state premium taxes*. . . ." H.R. REP. No. 881, 101st Cong., 2d Sess. 173 (1990) *reprinted in* 1990 U.S.C.C.A.N. 2017, 2181 (emphasis added). Similarly, the Senate Report stated, in relevant part, that:

> Under current law, FEHB insurance carriers are required to pay state premium taxes. These taxes are built into the program's premium base. Exempting carriers from paying this tax would result in a premium reduction (which of course, reduces the government's share) . . . .

136 CONG. REC. S15,715 (daily ed. Oct. 18, 1990, pt. 1). Moreover, FEHBA regulations indicate that the statute's preemption provision is directed at premium taxes:

> 5 U.S.C. § 8909(f) . . . applies to all forms of direct and indirect measurements *on FEHBP premiums*, however modified, to include cost per contract or enrollee, with the sole exception of a tax on net income

> or profit, if that tax, fee, or payment is applicable to a broad range of business activity.

48 C.F.R. § 1631.205-41 (1991) (emphasis added). The Second Circuit improperly deferred to non-binding OPM opinion letters that recited OPM's belief that FEHBA preempts the 11% state assessment imposed on commercial insurers,[20] rather than to the agency's own duly-promulgated regulations.

Congress expressly delegated to OPM the authority to promulgate regulations necessary to execute FEHBA's provisions. 5 U.S.C. § 8913(a) (1988). In its final regulations "to implement the State premium tax provisions of section 7002(c) of Public Law 101-508," 56 Fed. Reg. 57,496 (Nov. 12, 1991), OPM explained: "This legislation exempts Federal Employee Health Benefits (FEHB") Program carriers, underwriters, and plan administrators *from State taxes on FEHB premiums.*" *Id.* (emphasis added).

OPM's regulations prohibiting payment of State premium taxes are legislative rules. *See General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984). They were promulgated to implement the FEHBA preemption provision pursuant to an express delegation of authority, they use mandatory language to declare state premium taxes "unallowable costs," and they require that all FEHB contracts based on cost analysis include a clause incorporating OPM's definition of "premium taxes" into their text. 48 C.F.R. § 1652.216-71(b)(2)(iv)(B) (1992). Because the regulations are legislative rules, they have the force of law, and are binding upon the agency which promulgated them. *E.g., United States v. Nixon*, 418 U.S. 683, 695-96 (1974); *Morton v. Ruiz*, 415 U.S. 199, 235 (1974). Therefore, OPM's opinion letters and any other interpretive materials which contradict the regu-

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[20] These letters rendered no opinion on the 13% differential. Nevertheless, the Second Circuit deferred to the opinion letters as if they had.

lations are invalid so long as the regulations are in effect. *National Medical Enters. v. Bowen*, 851 F.2d 291, 293-94 (9th Cir. 1988). ("A regulation has the force of law; therefore, an agency's interpretation of a statute in a manner inconsistent with a regulation will not be enforced.") It was error, therefore, for the Second Circuit to defer to the opinion letters, and not to the regulations themselves.

CONCLUSION

It is respectfully requested that this Court grant HANYS' petition for a writ of certiorari.

Respectfully submitted,

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March 9, 1994

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Nos. 93-1408, 93-1414 and 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation of Caption See Reverse Side of Cover)

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

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38 pp

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Whether the United States Court of Appeals for the Second Circuit correctly applied this Court's Employee Retirement Income Security Act of 1974 ("ERISA") preemption cases, which time and again have invalidated State laws that "relate to" ERISA plans, in enjoining enforcement of State statutory hospital surcharges that drive ERISA plans' choices among alternative forms of health care coverage.

2. Whether the United States Court of Appeals for the Second Circuit correctly applied this Court's precedents in holding that certain of the challenged surcharges are not "saved" from preemption as laws regulating the business of insurance.

3. Whether the United States Court of Appeals for the Second Circuit correctly interpreted certain provisions of the Federal Employees Health Benefits Act ("FEHBA") as requiring preemption of certain of the challenged surcharges, and correctly deferred to the reasonable interpretation of that statute made by the agency charged with its enforcement.

RULE 29.1 STATEMENT

This brief in opposition is submitted on behalf of the following respondents, whose parent companies and subsidiaries (except wholly-owned subsidiaries) are indicated below, pursuant to Supreme Court Rule 29.1.

1. **The Travelers Insurance Company**
   Parents: The Travelers Inc. (formerly Primerica Corporation, successor to The Travelers Corporation); Associated Madison Companies, Inc.; and The Travelers Insurance Group Inc.

   Subsidiaries: Commercial Credit Company; Smith Barney Shearson Holdings Inc.; and Travelers Mortgage Securities Corporation.

2. **Health Insurance Association of America**
   None.

3. **American Council of Life Insurance**
   None.

4. **Life Insurance Council of New York, Inc.**
   None.

5. **Aetna Life Insurance Company**
   Parent: Aetna Life and Casulty Company.

   Subsidiaries: Aetna Health Plans of Colorado, Inc.; Aetna Health Plans of Florida, Inc.; Aetna Health Plans of San Diego, inc.; Partners Health Plan of Pennsylvania, Inc.; Aetna Series Fund, Inc.; HEALTHWAYS, Inc.; Med Southwest, Inc.; and PHPSNE Parent Corporation.

6. **Aetna Health Plans of New York, Inc.**
Parents: Aetna Life and Casualty Company; Aetna Life Insurance Company; AHP Holdings, Inc.; and HEALTHWAYS Systems, Inc.

7. **Mutual of Omaha Insurance Company**
Subsidiary: Preferred HealthAlliance, Inc.

8. **The Union Labor Life Insurance Company**
None.

9. **Professional Insurance Agents of New York, Inc. Trust**
None.

Respondents Health Insurance Association of America, American Council of Life Insurance and Life Insurance Council of New York, Inc. are independent trade associations. Their members number in the hundreds, and a listing of these members is set forth at "Addendum A" to respondents' brief in the United States Court of Appeals for the Second Circuit.

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REASONS FOR DENYING THE WRIT 13

POINT I

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BRIEF IN OPPOSITION

In their zeal to obtain further review, petitioners[1] have misrepresented the breadth of the Second Circuit's decision and its potential impact. In this Court, as in the courts below, petitioners have characterized this case as a challenge to a State's power to regulate hospital rates. This is fundamentally wrong. The issues presented by this case are far narrower, and do not warrant consideration by this Court.

This case involves New York State's attempt to drive ERISA plans' choices among alternative forms of health care coverage for their participants and beneficiaries. Essentially, New York State created a series of surcharges which were designed to force ERISA plans to provide their members with coverage for inpatient hospital care through New York's publicly-subsidized Blue Cross system, rather than through commercial or self insurance. In finding that the surcharge laws at issue "relate to" ERISA plans and are not "saved" as laws regulating the business of insurance, the Second Circuit did nothing more than apply this Court's well-established interpretation of ERISA's

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[1] In No. 93-1408, the petitioners are the New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively, "the Blues"). In No. 93-1414, the petitioners are New York State officials who (or whose predecessors) were defendants in the District Court. Herein, these petitioners will be referred to as "the State" or "New York State." In No. 93-1415, the petitioner is the Hospital Association of New York State ("HANYS").

preemption clause -- a clause this Court has described as "conspicuous for its breadth."

Moreover, the decision of the Second Circuit will have little impact on the functioning of New York's system of reimbursement for hospital care. Respondents have always paid (and continue to pay) the 13% surcharge. They did so while their challenge to it was pending in the District Court; shortly after the District Court upheld the challenge and enjoined New York State from enforcing the 13% surcharge, it granted a motion to stay this injunction pending appeal. On August 10, 1993, before the Second Circuit ruled on petitioners' appeal, Congress passed the Omnibus Budget Reconciliation Act of 1993 (the "Budget Act"). Section 13442 of the Budget Act amends Section 162 of the Internal Revenue Code, which governs trade or business deductions.[2] Essentially, Section 13442 operates as follows: for services provided after February 2, 1993, and on or before May 12, 1995, employers will lose their tax deductions for any amounts paid or incurred in connection with their group health plans if these plans do not pay the challenged surcharges in connection with their reimbursement for inpatient hospital care services provided in the State of New York. Because of the enormous financial incentive ERISA plans face to do so, all of the respondents are paying the 13% surcharge despite their preemption victory in the Second Circuit.[3] Further, in the face of

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[2] Section 13442 is reproduced at Addendum 1 to this brief.

[3] As noted, on February 9, 1993, the District Court stayed its February 3 order enjoining enforcement of the surcharges -- but only with respect to the 13% surcharge. (*See* A-94 to A-98.) For this reason as well, the respondents are paying it. Should this Court

(continued...)

respondents' successful challenge below, the New York Legislature recently re-enacted the 13% surcharge. (*See* Blues' Petition at p. 5.) As a consequence of the Budget Act and reenactment of this differential, New York hospitals will continue to receive the 13% surcharge. Thus, any pronouncement by this Court on the merits of the Second Circuit's decision regarding the 13% surcharge would amount to a mere advisory opinion.

Second, the 11% surcharge no longer exists. By the terms of the statute creating it, it was to apply only to hospital patients discharged during the period April 1, 1992 to March 31, 1993. Since this surcharge has lapsed by operation of the statute creating it, the decision of the Second Circuit regarding this issue has no prospective significance or impact, and the Second Circuit's rulings thereon do not warrant certiorari.

In addition, contrary to petitioners' contentions, there is no conflict between the Second Circuit's decision in this case and the Third Circuit's decision in *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). *United Wire* is distinguishable for the reasons stated below.

Finally, petitioners argue that the issues presented herein are of substantial national importance because the Second Circuit's ruling threatens the power of the States to exercise one of their fundamental police powers: "the regulation of health care and the control

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[3](...continued)
deny review, the Second Circuit's mandate will issue shortly thereafter, thus dissolving the District Court's stay order.

of its costs." (*See, e.g.*, HANYS's Petition at p. 16.) The issues in this case, however, involve much narrower, straightforward questions of ERISA and FEHBA preemption. The Court of Appeals correctly resolved these questions. Finally, the many district court cases petitioners cite (*see* State's Petition at 14-15 n.10; Blues' Petition at 18 n.25; HANYS's Petition at 18), in an attempt to demonstrate the national importance of this case, are totally inapposite. Unlike those cases, this case does not involve a challenge to the DRG rate-setting system. It does not call into question bad debt and charity care allowances or balance billing laws.

COUNTERSTATEMENT OF THE CASE

A. General Background.

In the District Court, respondents established that most Americans (excluding those qualifying for programs like Medicare and Medicaid) receive their health care coverage through employee welfare benefit plans governed by ERISA (JA-373-74, 379, 386-87, 391, 403).[4]

Employers and other plan sponsors that establish welfare plans subject to ERISA provide health and hospital coverage to their employees through a variety of methods, including (a) commercial health insurance contracts; (b) self insurance (in which a plan is directly responsible for medical and hospital bills and may or may not carry excess liability coverage); (c)

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[4] The Joint Appendix filed in the United States Court of Appeals for the Second Circuit will be cited herein as "(JA-___)." The separately bound Appendix filed in this Court with the petitions for certiorari will be cited as "(A-___)."

subscriptions to an HMO; or (d) coverage through a non-profit corporation such as Blue Cross/Blue Shield. (JA-372.)

An ERISA plan using commercial health insurance contracts with an insurer which reimburses certain health care costs incurred by plan participants and their beneficiaries, in exchange for a premium calculated to cover the costs of paying claims and administering the policy.

ERISA plans that are self-insured directly assume responsibility for the costs of health care, including in-patient hospital care, for their participants. Under some self-insured plans, the employer covers the full cost of the covered health care; under others, contributions from employees are required. Employers frequently retain a commercial insurer to administer claims and perform other administrative functions for self-insured plans. (JA-373.)

ERISA plans that use HMOs pay the HMO a predetermined premium or rate in return for providing health care services to plan participants. (JA-373.)

The Blues are non-profit corporations organized pursuant to Article 43 of the New York Insurance Law. These corporations contract directly with hospitals to provide services to individuals or members of groups subscribing to Blue Cross/Blue Shield.

B. New York's Approach to Hospital Rate Regulation.

New York State regulates the rates at which hospitals are reimbursed for the costs of in-patient care. For most patients, the rates for in-patient hospital care

are set on the basis of categories relating to the diagnoses of patients' illnesses. These categories are known as "Diagnosis Related Groups," or "DRGs." Pursuant to this system, the amount charged for in-patient hospital care is set on the basis of the DRG in to which the patient falls rather than on the actual cost of treatment. Furthermore, the actual amount charged for in-patient hospital care varies depending on the type of health care coverage -- *i.e.*, self insurance, commercial insurance, HMO membership or Blue Cross/Blue Shield -- provided to the patient.

New York Public Health Law Section 2807-c(1)(b) requires that the DRG rate for in-patient services be increased by a 13% surcharge when the patient is covered by any form of health plan (including, specifically, commercially-insured and self-insured employee benefit plans), except for patients covered by the Blues, an HMO, or government plans like Medicare. (A-102 to A-103.) The funds generated by the 13% surcharge are retained by hospitals, and are available to cover all of the operating and capital expenses of their business. (JA-1260.)

In the District Court, the State conceded that the purpose of the 13% surcharge was to encourage users of hospital services to select Blue Cross coverage. For example, James W. Clyne, New York's Deputy Superintendent of Insurance, stated that the 13% differential was meant to "level the playing field" for the Blues "in their competition with commercial insurers . . . ." (JA-649; *see* New York State's Memorandum of Law in Opposition to Plaintiffs' Motions for Summary Judgment at 37.)

Section 348 of New York's Omnibus Revenue Act of 1992, adopted on April 2, 1992 (the "Omnibus Act"),

amended Section 2807-c of New York's Public Health Law to impose an additional 11% surcharge on DRG payment rates charged by hospitals to patients covered by commercial insurance. Consequently, the total surcharge for commercially-insured patients -- and thus the differential between the Blues' and commercial insurers' charges -- was raised to 24%. (A-104.)[5]

In contrast with the funds generated by the 13% surcharge, however, the proceeds of the 11% surcharge ultimately were to be paid to New York State. They were not used to reimburse hospitals. Section 349 of the Omnibus Act required hospitals to submit the funds raised by the 11% surcharge to a pool established by the Commissioner of Health, who, in turn, was required to deposit those monies into New York's general fund. (A-105.) Petitioner HANYS, which certainly is in a position to know, admits that the 11% surcharge was "not used to meet the costs that hospitals must incur. Rather, [it was] a means to raise revenue for the State." (HANYS's Petition at pp. 5-6 n.3.) The State concurs: "The 11% surcharge was enacted primarily to remedy the deterioration in the Blue Cross plans' financial position . . . . It was also intended to raise revenue for the State." (New York State's Petition at p. 6; *see also* Blues' Petition at p. 5.)

The Omnibus Act also imposed a new surcharge on HMOs. Section 346 of the Act sets forth several methods for determining the standardized rate applicable to in-patient care rendered to HMO subscribers, ranging from the DRG rate to standardized

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[5] The 11% surcharge was created to apply to patients discharged during the one-year period from April 1, 1992 through March 31, 1993. (A-104.) Accordingly, the 11% surcharge lapsed long ago.

rates negotiated by the particular HMO. It also amends New York's Public Health Law to impose a surcharge of up to 9% on the cost of in-patient hospitalization paid by HMOs. This surcharge may be reduced for HMOs that provide certain services or achieve certain goals or may be partially or totally eliminated in some circumstances. (A-106 to A-107.) Section 346 requires each HMO to pay the amount it owes each month for the HMO surcharge into a statewide pool to be established by the Commissioner of Social Services of New York State, for deposit in to the State's general fund. (A-111.) Like the 11% surcharge, the 9% assessment has nothing to do with hospital reimbursement. It is a means to raise revenue for New York State. (HANYS's Petition at 5-6 n.3.) Thus, contrary to petitioners' assertions, the surcharge laws at issue in this case have nothing to do with hospital cost containment.

In the District Court, the State and the Blues characterized the 11% surcharge as a mere extension of the 13% surcharge, contending that the function of both is to level the competitive playing field between the Blues (on the one hand) and the commercial insurance industry (on the other). The Blues frankly admitted in the court below that one of the points behind increasing the 13% surcharge to 24% was to make purchasers of commercial health insurance, which are overwhelmingly ERISA plans, "think twice as hard" about using a commercial insurer rather than the Blues. (JA-821; *see also* JA-978-79.)

C. The Impact of the Surcharge Laws.

New York's surcharges substantially increase the costs to ERISA plans of providing benefits, if the ERISA plans provide such benefits through commercial

insurance, self insurance, or HMOs. Because self-insured plans undertake to pay for covered medical services provided to their participants, they must directly pay the 13% surcharge. Similarly, commercial insurance policies often provide that the premiums charged will depend on the amount of benefits paid. In those situations, the plans bear the 13% and 11% surcharges. More generally, the premiums charged for insurance, or the fees charged by HMOs, must be set at a level that will recapture the costs of providing benefits. State laws increasing those costs -- here, the 13%, 11% and HMO surcharges -- directly increase the amounts that ERISA plans must pay to provide a given level of benefits. (JA-388, 391, 396, 404.)

In the court below, respondents demonstrated the financial impact of the surcharges. The Second Circuit specifically found that the "surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits[,]" thus leading ERISA plans "to increase either plan costs or reduce plan benefits." (A-23.)

Thus, when a plan sponsor chooses self insurance, commercial insurance or an HMO to provide benefits, it must either pay higher costs reflecting the surcharges to provide the same level of benefits, or it must reduce benefits to offset these additional costs. Moreover, these additional costs inevitably divert plan resources from the provision of health care benefits to plan participants, in order to subsidize the general revenue needs of the State of New York (in the case of the 11% and 9% surcharges) or hospitals' general revenue needs (in the case of the 13% surcharge). The impact of these surcharges has been enormous, costing plan sponsors or plan participants hundreds of millions of dollars annually.

D. Proceedings in the District Court.

In two separate actions that were consolidated before Judge Freeh in the Southern District of New York, respondents challenged each of the surcharges as preempted by ERISA.

Respondents did not challenge New York's ability to regulate hospital rates through the use of a DRG system. Nor did they challenge the bad debt and charity care components of New York's DRG system.

Respondent Mutual of Omaha Insurance Company also maintained that the 11% and 13% surcharges are preempted by FEHBA. On cross-motions for summary judgment, the District Court issued an opinion and order on February 3, 1993 sustaining respondents' challenges.

First, Judge Freeh found that the surcharges have the requisite "connection with" ERISA plans, and therefore "relate to" such plans, because they were designed to drive ERISA plans' choices regarding the form of health care coverage to furnish their participants; and they have a significant economic effect on commercial carriers and HMOs providing coverage to ERISA plans. (A-72.)

Next, Judge Freeh found that the surcharges are not "saved" from preemption as laws regulating the business of insurance.[6]

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[6] In both the District Court and the Court of Appeals, petitioners did not raise the savings clause issue with respect to the 9% surcharge. Accordingly, the savings clause discussion in the text is limited to the 11% and 13% surcharges.

Finally, Judge Freeh rejected petitioners' contention that FEHBA's preemption provision applies only to state "premium taxes," and ruled that the 11% and 13% surcharges are preempted by FEHBA. In doing so, he deferred to the reasonable interpretation accorded FEHBA's preemption provision by the Office of Personnel Management ("OPM"), the federal administrative agency that administers the FEHBA program.

On subsequent motions, the District Court stayed its ruling regarding the 13% surcharge.

E. Proceedings in the Second Circuit.

In a carefully balanced opinion, the Second Circuit concluded that the surcharge laws were preempted by ERISA and FEHBA and affirmed Judge Freeh's order as to these issues. Nothing in the Second Circuit's opinion casts doubt on New York's ability to regulate hospital rates.

The Second Circuit found that the challenged surcharges have the requisite "connection with" ERISA plans. First, the court noted that the 11% and 13% surcharges were designed to increase hospital costs for patients covered by health plans other than the Blues, thus making these competing plans less attractive than the Blues. (A-22.) It was thus "[o]bvious[]" that the surcharges will affect ERISA plans' health care benefits. Further, the 9% surcharge imposed on HMOs would interfere with a plan's selection of the most effective method to provide benefits. The Second Circuit had little difficulty in concluding, based upon the foregoing, that the surcharges "purposely interfere with the choices that ERISA plans make for health care coverage." (A-

22.) The court found such interference sufficient to constitute "connection with" ERISA plans. *(Id.)*

The Second Circuit also found that the surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. For this reason as well, the court found a sufficient impact with ERISA plans to constitute the requisite relation to ERISA plans. (A-23.)

The Second Circuit next affirmed Judge Freeh's ruling that the challenged surcharges are not saved from preemption as laws regulating the business of insurance. (A-25 to A-29.)

Finally, the Second Circuit rejected petitioners' interpretation of FEHBA. The court found that despite petitioners' references to the legislative history, they selectively ignored legislative policies that counter their interpretation of the statute. (A-15 to A-16.) Finally, the Second Circuit found that the District Court properly deferred to OPM's FEHBA interpretation and OPM regulations, and affirmed Judge Freeh's FEHBA preemption ruling.

On petitioners' motions, the Second Circuit stayed its mandate, pending disposition of the petitions for certiorari in this Court.

REASONS FOR DENYING THE WRIT

POINT I

THE SECOND CIRCUIT CORRECTLY APPLIED THIS COURT'S ESTABLISHED CONSTRUCTION OF ERISA's "RELAT[ING] TO" CLAUSE

Petitioners argue that the Second Circuit's ERISA preemption ruling merits review in this Court because of an alleged conflict in the circuits, and because the Second Circuit supposedly misread this Court's "relating to" precedents, thereby impermissibly expanding the scope of ERISA preemption to include laws of general application with merely remote, indirect effects on ERISA plans. None of these contentions is true.

In finding the challenged surcharges preempted in this case, the Second Circuit did nothing more than give effect to the broad, common-sense meaning that this Court has ascribed to ERISA's preemption clause time and time again. Nothing in the Second Circuit's opinion undermines a state's ability to regulate hospital rates.

This Court has repeatedly held that a law "relate[s] to" an ERISA plan, and is preempted, if it has a "connection with" or "reference to" such a plan. *See District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-39 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983).

In the District Court, New York State conceded that the purpose of the 13% surcharge was to encourage users of hospital services to select Blue Cross coverage. Thus, an official in the New York State Department of Insurance stated in an affidavit that the 13% surcharge was meant to "level the playing field" for the Blues "in their competition with commercial insurers . . . ." (JA-649.) In its brief in support of its motion for summary judgment, the State maintained:

> Just as the 11% is aimed at the insurance industry, so is the 13% which is, likewise, intended to level the playing field between Blue Cross and the commercial insurers.

(New York State's Memorandum of Law in Opposition to Plaintiffs' Motions for Summary Judgment at 37.) In the District Court, the Blues frankly admitted that one of the points behind increasing the 13% surcharge to 24% was to make purchasers of health insurance, which petitioners never disputed are overwhelmingly ERISA plans, "think twice as hard" about using a commercial insurer, rather than the Blues, to provide health coverage to group members. (JA-821; JA-978-79.)

These admissions demonstrate that the 11% and 13% surcharges were specifically designed to influence the choices of ERISA plans regarding the form of health care coverage furnished their participants and beneficiaries.

With these candid admissions on the record, as well as the evidence respondents adduced demonstrating the significant financial impact of the surcharges, the Second Circuit was on solid ground when it concluded:

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans.*

(A-22; emphasis added.)

Contrary to petitioners' contention, this unremarkable ruling is not in conflict with the Third Circuit's recent decision in *United Wire*, for the following reasons.

First, the cases are distinguishable on their facts. In *United Wire*, New Jersey officials did not admit, as New York officials did in this case, that any of the challenged components of New Jersey's hospital rate-setting scheme were specifically designed to make ERISA plans "think twice as hard" about choosing a particular form of health coverage. In light of the fact that the Third Circuit majority held that a law relates to an ERISA plan if it, *inter alia*, is "specifically designed to affect employee benefit plans," 995 F.2d at 1192 (footnote omitted), it remains an open question how the Third Circuit would rule were such an admission placed before it. For this reason alone, there is no conflict between the circuits.

Second, in reaching its decision, the *United Wire* court explicitly relied on the Second Circuit's ten-year old ruling in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

Rebaldo involved an ERISA preemption challenge, brought by a self-insured plan. The Second Circuit held that ERISA did not preclude New York from regulating hospital rates charged for services covered by self-insured plans by, among other things, preventing such plans from negotiating discounts with hospitals. In rejecting this challenge, the Second Circuit held that

> a state law must 'purport[] to regulate . . . the terms and conditions of employee benefit plans' to fall within the preemption provision.

749 F.2d at 137.

Like respondents did below, the *United Wire* plaintiffs argued that *Rebaldo* was no longer good law in light of this Court's ruling in *Ingersoll-Rand*, which expressly rejected a "purport to regulate" test. 498 U.S. at 138, 141. Further, in *Ingersoll-Rand*, this Court pointed out that pursuant to its broad reading of ERISA's preemption clause, a state law may be preempted "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Id.* at 139.

The Third Circuit stated that *Rebaldo* -- which it explicitly noted was the "most helpful" case in resolving the issue before it -- would have been decided in the same way had the Second Circuit had the benefit of *Ingersoll-Rand*'s teachings. 995 F.2d at 1193-94. Several months later, in the instant case, the Second Circuit proved the Third Circuit's prediction was faulty,

and, on the basis of *Ingersoll-Rand*, overruled *Rebaldo's* narrow reading of ERISA's preemption clause.

What this history shows is that there is no true conflict between the Second and Third Circuits; the Third Circuit quite clearly heavily relied on *Rebaldo*, and on its prediction of how the Second Circuit would have decided *Rebaldo* in light of *Ingersoll-Rand*. Now that the Third Circuit's prediction has proved to be incorrect, it remains an open question how the Third Circuit would rule on the ERISA preemption issue presented here in light of the Second Circuit's ruling below.

Finally, it must be stressed that two of the challenged surcharges in this case -- the 9% and the 11% -- have nothing to do with hospital reimbursement, or the containment of hospital costs. The funds associated with these surcharges end up in New York State's general fund. The Third Circuit had nothing of this kind before it.[7] Once again, therefore, it remains an open question how the Third Circuit would rule on the surcharges at issue in this case.

In sum, the Second Circuit correctly applied this Court's precedents in the ERISA preemption area, and properly found that the challenged surcharges "relate to"

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[7] In fact, it was dealing with just the opposite. Thus, at one point in its analysis, the District Court in *United Wire* concluded that "[t]he state never uses the money collected from plaintiffs for the general welfare. Additionally, the fees collected are never intermingled in a general fund." *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 793 F. Supp. 524, 531 (D.N.J. 1992), *rev'd on other grounds*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). This finding was not disturbed by the Third Circuit.

ERISA plans. It did not, as petitioners contend, destroy a state's ability to regulate hospital rates, establish and maintain a state's DRG system or set up bad debt and charity care components in its overall hospital rate-setting system. These issues were not before the Court of Appeals. Finally, the Second Circuit did not place itself in conflict with the Third.

For these reasons, a writ of certiorari should not issue.

POINT II

THE SECOND CIRCUIT CORRECTLY APPLIED THIS COURT'S PRECEDENTS IN CONCLUDING THAT THE SURCHARGES ARE NOT SAVED FROM PREEMPTION AS LAWS REGULATING THE BUSINESS OF INSURANCE

The Blues request this Court to review the Second Circuit's ruling that the challenged surcharges are not saved from preemption under ERISA's savings clause.[8] They do not contend that a conflict in the circuits exists as to this issue. Rather, they argue that the Second Circuit failed to follow this Court's common-sense view of the savings clause, and that it "seem[ed] to require" that all three McCarran-Ferguson criteria be satisfied for a state law to be saved from preemption. (*See* Blues' Petition at 15-16.) Neither contention has merit. They certainly do not warrant certiorari.

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[8] The Blues do not raise the savings clause issue with respect to the 9% surcharge. Accordingly, the discussion in the text is limited to the 11% and 13% surcharges.

At the outset, it is important to note that the State of New York -- the political entity which created the surcharge laws at issue in this case -- has not asked this Court to review the Second Circuit's holding that the surcharge laws are not laws regulating insurance within the meaning of ERISA's preemption clause. In fact, in the Second Circuit, the State raised this issue only with regard to the 11% surcharge. (*See* New York State's Brief at 33 n.42.) Surely, if the State of New York does not believe that the ruling of the Second Circuit will interfere with its ability to regulate insurance, there is absolutely no reason for this Court to consider the issue.

Furthermore, the Second Circuit applied settled principles to a straightforward savings clause issue. It properly engaged in the common-sense determination as to whether the challenged surcharges are laws regulating the "business of insurance." *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40 (1985). It then applied the three criteria the courts have established to determine whether a practice constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* *See The Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

With regard to the 11% surcharge, the Blues completely fail to mention that under Section 348 of the Omnibus Act, commercial insurers were not directly obligated to pay the 11% surcharge. The law required hospitals to add the surcharge onto the bills of patients covered by commercial insurance, and to turn the proceeds over to the State. (A-105.) If the surcharge was not paid, the hospital -- not the commercial insurer

-- could have been subject to penalties.[9] Indeed, the State deliberately chose not to impose the 11% surcharge on insurance companies in order to avoid any characterization of the law as a tax on insurers. (JA-1232.) Thus, the Court of Appeals correctly found that the 11% surcharge fails the common-sense inquiry. The real burden of paying it fell on New York hospitals.

The Second Circuit also correctly found that the 13% surcharge fails the common-sense inquiry. It governs the relationship between hospitals and their patients.

The Court of Appeals then applied the McCarran-Ferguson criteria. It found that the surcharges do not dictate any of the terms of the insurance contract itself; rather, as the Second Circuit correctly found, they relate only to the contractual obligations between hospitals and insurers or insureds. (A-29.) Further, the surcharges are not limited to entities within the insurance industry -- involving as they do the State, hospitals, patients, HMOs and self-insured funds. For the foregoing reasons, the Second Circuit concluded that the surcharges fail two of the McCarran-Ferguson criteria.

In sum, the Court of Appeals found that the surcharges are not saved from preemption because they fail the common-sense inquiry plus two of the three McCarran-Ferguson criteria. The court did not hold, as the Blues argue, that all three McCarran-Ferguson criteria must be satisfied to save a state law from preemption. Notably, the Blues have not cited any

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[9] *See* 1992 N.Y. Laws, ch. 41, § 104, *reproduced at* Addendum 2 hereto.

language in the court's opinion to that effect. Despite the Blues' complaint that the Second Circuit read the savings clause too narrowly, the court correctly balanced the legislative purposes behind the "relat[ing] to" and "savings" prongs of ERISA's preemption clause. Since the Second Circuit applied established principles in a simple factual context, there is no reason for this Court to consider the savings clause issue presented by this case.

POINT III

THE SECOND CIRCUIT CORRECTLY INTERPRETED FEHBA AS PREEMPTING THE SURCHARGES, AND CORRECTLY DEFERRED TO OPM's IDENTICAL INTERPRETATION OF FEHBA

Finally, Petitioner HANYS seeks certiorari to review the Second Circuit's ruling that FEHBA preempts the 11% and 13% surcharges. HANYS concedes that there exists no conflict in the circuits regarding this issue. It argues that FEHBA's prohibition of any tax, fee or monetary payment with respect to payments from the Federal Employee Health Benefits ("FEHB") Fund applies to premium taxes. It contends that the 13% surcharge simply determines the amounts that hospitals must bill their patients; it does not constitute an extra tax, fee or monetary payment with respect to such rates.[10]

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[10] Respondent Mutual of Omaha challenged both the 11% and 13% surcharges as preempted by FEHBA. Since HANYS makes it very clear in the initial pages of its petition that it "takes no position on the 11%" surcharge since it is simply a State revenue-raising measure and not hospital reimbursement (*see* HANYS's

(continued...)

At bottom, HANYS is asking this Court to review a ruling that is solidly grounded in: (1) the language of the statute; (2) its legislative history; and (3) a reasonable interpretation of the governing statute and applicable regulations by the administrative agency charged with administering the FEHB Program.

FEHBA, 5 U.S.C. § 8901, *et seq.* (Supp. IV 1992), creates a program under which federal employees' health coverage is paid for in part by their federal government employer. In creating this program, Congress intended to reduce the cost to the federal government of the Federal Employees Health Benefit ("FEHB") program by prohibiting, with limited exceptions, state and local governments "directly or indirectly" from taxing or surcharging any payments from the government in connection with the FEHB program. Section 8909(f) states that "[n]o tax, fee or other monetary payment may be imposed, directly or indirectly, on a carrier or underwriting plan administration subcontractor . . . by any State . . . with respect to any payment made from the Fund." (A-100.)

Respondent Mutual of Omaha sued to enjoin enforcement of the 11% and 13% surcharges as preempted by FEHBA. Petitioners cross-moved for summary judgment on the ground that FEHBA only applies to "premium taxes." The Second Circuit affirmed the District Court's rejection of this argument.

---

[10](...continued)
Petition at 5-6 n.3), its petition for certiorari should be read as seeking review only of the Second Circuit's FEHBA ruling regarding the 13% surcharge. Of course, respondents' FEHBA arguments are equally applicable to both surcharges.

Both courts found that contrary to HANYS's arguments, the FEHBA statute does not clearly refer to state premium taxes. The statute itself refers only to a "tax, fee or other monetary payment" imposed "directly or indirectly" on "any payment made from the Fund." (A-85-86.) The District Court deferred to OPM's administrative interpretation that FEHBA preempts the 11% and 13% surcharges. The District Court noted that there was no dispute that the surcharges substantially increase the amount that FEHBA carriers must pay for hospital care. These carriers are reimbursed for payments by the Fund; therefore, the surcharges serve to increase payments from the Fund. Thus, OPM's determination of preemption under Section 8909(f) is a "reasonable interpretation of the statute" warranting deference. (A-86.) *See Chemical Manufacturers Association v. Natural Resources Defense Council*, 470 U.S. 116, 125 (1985); *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984).

The Second Circuit rejected petitioner's attempt to reargue these propositions on appeal. In fact, the Second Circuit explicitly noted that petitioners "selectively ignore[d] legislative policies that run counter to their interpretation of the statute." For example, the central purpose of Section 8909(f)(1) was to reduce expenditures from the Fund by preventing states from charging taxes on health care reimbursements drawn by carriers from the Fund. (A-16.) The Second Circuit also approved of the District Court's deference to OPM's administrative interpretation of Section 8909(f)(1). OPM's interpretation was rendered before the government entered this litigation. (A-17.)

Petitioners have adduced no reason why the Second Circuit's FEHBA ruling warrants this Court's

review pursuant to Supreme Court Rule 10. Accordingly, its attempt to win review of that ruling should be rejected.

CONCLUSION

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

Respectfully submitted,

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Dated: New York, New York
April 7, 1994

ADDENDUM 1

Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, § 13442.

SPECIAL RULE FOR HOSPITAL SERVICES.

(a) IN GENERAL. -- Section 162 (relating to trade or business deductions), as amended by section 13211, is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

"(n) SPECIAL RULE FOR CERTAIN GROUP HEALTH PLANS. --

"(1) IN GENERAL. -- No deduction shall be allowed under this chapter to an employer for any amount paid or incurred in connection with a group health plan if the plan does not reimburse for inpatient hospital care services provided in the State of New York --

"(A) except as provided in subparagraphs (B) and (C), at the same rate as licensed commercial insurers are required to reimburse hospitals for such services when such reimbursement is not through such a plan,

"(B) in the case of any reimbursement through a health maintenance organization, at the same rate as health maintenance organizations are required to reimburse hospitals for such services for individuals not covered by such a plan (determined without regard to any government-supported individuals exempt from such rate), or

"(C) in the case of any reimbursement through any corporation organized under Article 43 of the New York State Insurance Law, at the same rate as any such corporation is required to reimburse hospitals for such services for individuals not covered by such a plan.

"(2) STATE LAW EXCEPTION. -- Paragraph (1) shall not apply to any group health plan which is not required under the laws of the State of New York (determined without regard to this subsection or other provisions of Federal law) to reimburse at the rates provided in paragraph (1).

"(3) GROUP HEALTH PLAN. -- For purposes of this subsection, the term 'group health plan' means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to any employee, any former employee, the employer, or any other individual associated or formerly associated with the employer in a business relationship, or any member of their family."

(b) EFFECTIVE DATE. -- The provisions of this section shall apply to services provided after February 2, 1993, and on or before May 12, 1995.

ADDENDUM 2

1992 N.Y. Laws, ch. 41, § 104

Subdivision 20 of section 2807-c of the public health law is amended by adding a new paragraph (c) to read as follows:

(c)(i) Interest shall be due and payable to the commissioner by a general hospital or by a payor paying directly to a pool on the difference between the amount paid to a pool and the amount due to such pool by the hospital or payor from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest may be collected by the commissioner in the same manner as an arrearage pursuant to this subdivision.

(ii) If a payment by a general hospital or by a payor paying directly to a pool is less than seventy percent of the amount due to such pool by the hospital or payor, a penalty shall be due and payable to the commissioner by the hospital or payor of five percent of the difference between the amount paid to the pool and the amount due to such pool when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty may be collected by the commissioner in the same manner as an arrearage pursuant to this subdivision.

(3) (4) (3)

Nos. 93-1408, 93-1414, 93-1415

Supreme Court, U.S.
FILED
APR 8 1994
OF THE CLERK

IN THE

Supreme Court of the United States

October Term, 1993

MARIO M. CUOMO, in his official Capacity as Governor of the State of New York; MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York; SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York; MARY JO BANE, in her Official Capacity as Commissioner of Social Services of the State of New York; and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York; NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD; and HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

against

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

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32 pp

Counterstatement of Question Presented

Whether the Second Circuit Court of Appeals correctly held that section 2807-c (2-a) of New York's Public Health Law, which increases the cost of health care coverage provided by a health maintenance organization ("HMO") to an employee benefit plan if the HMO is unable to enroll a targeted number of Medicaid recipients, is preempted by ERISA?

Supreme Court Rule 29.1 Statement

Pursuant to Supreme Court Rule 29.1, the respondents listed below have the following parent companies and subsidiaries (except wholly owned subsidiaries):

Oxford Health Plans (NY), Inc.
PARENT COMPANY: Oxford Health Plans, Inc.

Physicians Health Services of New York, Inc.
PARENT COMPANY: Physicians Health Services, Inc.

Preferred Care
PARENT COMPANY: Preferred Care Holding Co.

Travelers Health Network of New York, Inc.
PARENT COMPANIES: Travelers Health Network, Inc.;
Travelers Health Co., Inc.;
Travelers Employee Benefits Co., Inc.;
Travelers Insurance Co.;
The Travelers Inc. (formerly Primerica Corp., successor to The Travelers Corp.);
Associated Madison Companies, Inc.;
and
The Travelers Insurance Group, Inc.

U.S. Healthcare, Inc.
PARENT COMPANY: U.S. Healthcare, Inc.

Wellcare of New York
PARENT COMPANY: Wellcare Management Group, Inc.

The remainder of the respondents do not have any parent companies or subsidiaries, other than wholly owned subsidiaries.

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Nos. 93-1408, 93-1414, 93-1415

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993.

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, *et al.*,

Petitioners,

against

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

Brief in Opposition to Petitions for a Writ of Certiorari

Counterstatement of the Case

Preliminary Statement

This brief is submitted on behalf of the respondents New York State Health Maintenance Organization Conference and twelve health maintenance organizations (collectively referred to as the "HMOs")[1] in opposition to the petitions for a writ of certiorari of Mario M. Cuomo *et al.* (collectively referred to herein as "the State"), New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively referred to herein as "the Blues") and the Hospital Association of New York State (referred to herein as "HANYS"). Petitioners seek review of a judgment of the United States Court of Appeals for the Second Circuit that affirmed the District Court's February 3, 1993 Opinion and Order of Judge Louis Freeh. Judge Freeh held, *inter alia*, that the Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001 *et seq.* (West 1985 & Supp. 1992) (hereinafter "ERISA"), preempts Section 2807-c (2-a) of the New York Public Health Law, which imposes a penalty, calculated at 9% of the HMOs' aggregate cost of hospitalization, on HMOs that fail to enroll a specified number of Medicaid patients.[2]

---

[1]The twelve HMOs are Health Services Medical Corporation of Central New York, Inc., MVP Health Plan, Inc., Wellcare of New York, Inc., Mid-Hudson Health Plan, Inc., Oxford Health Plans (NY), Inc., Capital District Physicians' Health Plan, Inc., ChoiceCare Long Island, Inc., Independent Health Association, Inc., Travelers Health Network of New York, Inc. Physicians Health Services of New York, Inc., Preferred Care, Inc. and U.S. Healthcare, Inc.

[2]Although the disputed statute imposes surcharges of 9, 11 and 13%, the HMOs are subjected only to the 9% assessment and this brief only addresses preemption of that assessment.

Although petitioners attempt to drape their arguments equally over the 9%, 11% and 13% assessments, there are critical differences between the 9% assessment levied on HMOs and the 11% and 13% surcharges imposed on commercial insurers. Similarly, petitioners gloss over the significant differences between HMOs, which actually provide care, and fee-for-service indemnity insurance companies. These differences make petitioners' arguments in favor of certiorari not only unpersuasive but also largely irrelevant as applied to the 9% assessment.

HMOs And Their Role In New York's Health Care System

The New York State Health Maintenance Organization Conference is a not-for-profit corporation consisting of 27 health maintenance organizations licensed to operate in and located throughout New York State. The HMOs in the Conference currently provide health care to more than three million people in New York.

HMO coverage differs from traditional health insurance. By combining the provision and financing of comprehensive health care, including primary and specialty physician care, with inpatient hospitalization, HMOs are able to provide quality health care in a cost efficient manner. HMOs accomplish this through a variety of contractual arrangements with doctors, other providers and hospitals.[3]

Unlike commercial insurance companies and the Blue Cross/Blue Shield indemnity insurance plans, HMOs serve

[3]For example, some HMOs (group and staff models) employ their own physicians. Other HMOs (individual practice associations) use networks of physicians who agree to serve the HMO's subscribers and to adhere to the HMO's practice and payment guidelines.

Medicaid recipients. Under the State's Medicaid managed care program, HMOs enroll Medicaid recipients into their provider networks and receive a fixed monthly rate for each individual. HMOs also ensure that Medicaid recipients and their families have a primary physician to monitor their care on a regular basis. The use of a primary care physician and the availability of a health care network provide Medicaid recipients with better access to primary and preventive care than otherwise available under the traditional fee-for-service system and helps reduce costly emergency room visits. (JA 1550, ¶ 10)[4].

HMOs And Employee Benefit Plans

HMOs are required by state and federal law to offer a comprehensive health benefits package. 42 C.F.R. § 417 (1992); N.Y. Pub. Health Law § 4403 (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.6 (1992). Because of the State's regulatory requirements, HMOs may not revise their benefits packages at will and may not reduce their core package beyond a certain level of benefits.

Under state law, employers generally are required to offer HMOs as a health benefit option to their employees. N.Y. Pub. Health Law § 4407 (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.15 (1992). Most HMO contracts are with employee benefit plans.

When an employee benefit plan contracts with an HMO, the employees and their dependents must each select a primary care physician who has the responsibility to over-

[4]"(A—)" refers to the Appendix filed by Petitioners herein. "(JA—)" refers to the Joint Appendix filed in the Court of Appeals. "(R—)" refers to the Record on Appeal in the Court of Appeals.

see and coordinate the care that is provided. By designating a single physician to coordinate care, there is one individual who knows the medical history and needs of each employee and the employee's family. In most cases, members must receive the approval of the primary care physician before seeing a specialist. HMOs also work closely with their members prior to and during hospitalization to ensure that there is adequate preparatory work and to minimize the length of the hospital stay. (JA 1551, ¶¶ 13, 14).

As noted above, in some cases the HMO's physicians are salaried employees of the HMO and are principally available only to serve the members of the HMO. Thus, if an employee benefit plan terminates its contract with such an HMO and switches to a different type of health care coverage, the employees and their families would not be able to continue to use the physicians who they have been using and who are most familiar with their medical history. (JA 1551, ¶ 15).

The New York Statute

Generally speaking, inpatient hospital care in New York is reimbursed on a case-based system, rather than on the charges that the hospital might otherwise impose. Upon entering a hospital, a patient is placed into a category known as a diagnosis-related group ("DRG") based on the patient's condition. The patient is then billed for the rate assigned to the appropriate DRG rather than for the actual cost of treatment incurred.

Since the inception of DRGs in 1988, the DRG rate has been increased by 13% for patients covered by commercial insurance or self-insured plans. N.Y. Pub. Health Law

§ 2807-c(1)(b) (McKinney 1993). The 13% surcharge is added to the patient's DRG rate, billed by the hospital and paid by the patient or insurer directly to the hospital. The revenue generated by the 13% surcharge is retained by the hospital.

On April 2, 1992, New York State adopted the Omnibus Revenue Act of 1992 (the "statute") which amended the Public Health Law to impose (1) an additional 11% surcharge on the DRG rates of patients insured by commercial insurers; and (2) a penalty calculated at 9% of an HMO's aggregate cost of hospital care payable to the State by HMOs that fail to enroll a target number of Medicaid recipients.

Like the 13% surcharge, the 11% surcharge is added to the patient's hospital bill and paid directly to the hospital. The funds generated by the 11% surcharge are forwarded by the hospital to a pool established by the Commissioner of Health and then deposited into the State's General Fund.

The 9% assessment applies only to HMOs and directly affects the employee benefit plans that HMOs serve. The statute imposes a penalty, payable to the State and calculated at 9% of an HMO's aggregate cost of inpatient hospital care, on HMOs that are unable to attain certain Medicaid enrollment objectives set by the State. The 9% assessment is not an increase in the actual DRG rates that HMOs pay hospitals. Rather, it is a separate charge that is based on the aggregate monthly cost of the inpatient hospitalization that is paid by the HMO. In effect, the HMO calculates the cost of its inpatient hospitalization, multiplies the total by 9% and pays this amount into a statewide pool. The funds are then deposited by a State-designated pool administrator into the State's

General Fund. The funds are never paid to the hospital providing the service.

Under the statute, an HMO can reduce or eliminate the 9% assessment if the HMO achieves certain Medicaid enrollment objectives. An HMO can eliminate the 9% assessment if the HMO (1) has Medicaid contracts with every county in which it operates and (2) enrolls a defined target number of Medicaid recipients. Thus, unlike the 13% and 11% differentials, the 9% assessment can be reduced or eliminated if the HMO achieves the State's objective of enrolling a sufficient number of Medicaid enrollees into the HMO's managed care network.

The 9% assessment at issue also differs sharply from the 13% differential and 11% surcharge because the 9% assessment is not an increase in the rate of payment to hospitals. The rate an HMO pays a hospital is unaffected by the 9% assessment, and the 9% assessment produces no revenue for hospitals.

The 9% assessment is not an attempt to regulate either the hospital reimbursement system or the insurance system. Rather, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid patients (JA 482, ¶ 27). A secondary purpose is to raise revenue for the State.

The 9% Assessment Has a Substantial Economic Impact on Employee Benefit Plans

Although HMOs can reduce or eliminate the 9% assessment if they fulfill the State's Medicaid objectives, it has been exceedingly difficult for some HMOs to do so. Indeed,

for any HMO that did not already have Medicaid contracts in place and a substantial enrollment at the time the statute was enacted, it was virtually impossible to satisfy the requirements for eliminating the assessment in 1992. (JA 15, ¶ 21). Only ten HMOs qualified either for an elimination or reduction of the 9% assessment for the 1992 rate period. (JA 761, ¶ 15).

Moreover, while some HMOs were able to eliminate or reduce the 9% surcharge for the 1992 year, (JA 761, ¶ 15), there is no assurance that they will continue to be able to do so because the enrollment target increases in succeeding years. In addition, because there is no corresponding mandate on Medicaid recipients to enroll in an HMO, some HMOs with sufficient enrollment in one year may lack the requisite enrollment in the next year and thereby become subject to the 9% surcharge. (JA 1553, ¶ 21). As the district court recognized, "HMOs which do not or cannot meet the statutory requirements must pay the full amount." (A 22).

The assessment has had an immediate and dramatic effect on the rates that HMOs charge their subscribers, including employee benefit plans. Because the cost of hospitalization accounts for approximately 40% of the overall costs of an HMO, the 9% surcharge translated into an immediate increase of up to 3.5% in total costs for most HMOs. (JA 1553, ¶ 22).

HMOs cannot absorb this increase. (JA 1554, ¶ 23). Many HMOs are not-for-profit, including seven of the respondent HMOs. Some HMOs do not have large financial reserves and cannot absorb major and unexpected costs such as the cost of the 9% assessment. They cannot use reserves to fund these increased costs because, in the rate setting

process, the State has placed limits on the size of an HMO's reserves and, more importantly, because the reserves must be retained in the event that an HMO experiences unusually heavy medical claims. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.11 (1992).

The impact of the 9% assessment has been substantial. For example, for the period July 1, 1992 through December 31, 1992, Independent Health of Western New York was required to pay approximately $2.5 million and MVP Health Plan was required to pay approximately $1.5 million as a result of the assessment. In the face of such substantial charges, the HMOs have had no recourse but to request rate increases in order to transfer the cost of the assessment to their subscribers. (JA 1550, ¶ 9).

The New York State Insurance Department, recognizing that the cost of the 9% assessment was an expense that HMOs could not absorb, has granted rate increases that reflect the amount of the 9% assessment. (JA 1554, ¶¶ 24, 25; *see* Exhibit "B" annexed to R 32 [JA 16]). For example, Oxford Health Plans was awarded a 2.6% increase for the last three months of 1992 "to reflect the 9% inpatient hospital surcharge it currently pays." (Exhibit "B" annexed to R 32 [JA 16]).

The District Court Decision

Respondents moved for summary judgment in the district court on the grounds that the 11% and 13% surcharges are preempted by the Federal Employees Health Benefits Act ("FEHBA") and that the 9%, 11% and 13% surcharges are preempted by ERISA. Petitioners cross-moved for summary judgment to dismiss the complaints.

By Opinion and Order dated February 3, 1993, Judge Louis J. Freeh held, *inter alia*, that all of the surcharges related to employee benefit plans and were preempted by ERISA. Rejecting the Second Circuit's then out-dated analysis in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), Judge Freeh held that the surcharges were preempted by ERISA because they imposed a substantial economic burden on employee benefit plans that was likely to affect the structure and/or administration of the plans. Specifically, Judge Freeh stated that the 9% assessment will force HMOs to transfer the cost of the assessment, via an increase in rates, to employee benefit plans. (A-71). Judge Freeh also noted that, in many cases, the assessment could result in a 2.5%-3.5% increase in the rates charged to subscribers. (A-71-72, nn. 6-7).

Significantly, Judge Freeh recognized that the additional revenue generated by the assessment is not applied to any use even remotely related to the health care of plan participants. (A-74). Thus, to the extent that the assessment diverts plan resources by directing that they be paid to the State, it has a substantial impact on ERISA plans—costing plan sponsors and participants millions of dollars annually.

Judge Freeh also held that the surcharges were not preserved by the insurance savings clause, which exempts from preemption laws regulating the business of insurance. As to the 9% assessment, the court held that it "could not possibly fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." (A-79).

The Second Circuit Decision

On January 14, 1994, the United States Court of Appeals for the Second Circuit issued an amended opinion affirming Judge Freeh's decision that ERISA preempted all of the challenged surcharges.[5] The court held that the surcharges were sufficiently "connected with" employee benefit plans to justify preemption. Noting that the 9% assessment interfered with an ERISA plan's selection of the most effective way to provide benefits, the court held that the surcharges purposely interfered with the choices that such plans make for health care coverage. Indeed, the court held that the surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits, thereby forcing ERISA plans "to increase either plan costs or reduce plan benefits." (A-23). Thus, the court held that the surcharges also have an impermissible impact on ERISA plan structure and administration. (A-24).

The court expressly declined to follow the Third Circuit's decision in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), on the grounds that it improperly relied on *Rebaldo v. Cuomo* and too narrowly interpreted ERISA's preemption provision.

Expressly adopting the district court's holding that HMOs are not, as a matter of law, insurance companies, the court also rejected the claim that any of the surcharges were preserved by the insurance savings clause.

[5]The amended opinion supplemented the court's earlier opinion by holding that the 11% and 13% surcharges were also preempted by FEHBA.

On March 7, 1994, the Second Circuit denied the motion of the Blues and HANYS that the court rehear the ERISA preemption issue *in banc*.

REASONS FOR DENYING THE WRIT

I. There is no Conflict Between the Circuits as to Preemption of A State Law that Increases an Employee Benefit Plan's Cost of HMO Health Care Coverage if the HMO is Unable to Enroll a Certain Number of Medicaid Recipients

Regardless of any conflict that petitioners claim exists between the Second Circuit's decision regarding the 11% and 13% surcharges and the Third Circuit's decision in *United Wire*, there is no conflict regarding the 9% assessment.

Petitioners do not deny that the 9% assessment has affected employee benefit plans. They do not dispute that the 9% assessment has caused, and will continue to cause, HMOs to increase the rates charged to their subscribers. Nor do they deny that these increases will be substantial. They also do not dispute that most HMO contracts are with employee benefit plans. Instead, they rely primarily on the Third Circuit's decision in *United Wire*, which involved a hospital rate statute far different from the one at issue here, to support their claim that the 9% assessment is not preempted by ERISA and that a conflict between the circuits exists.

The statute at issue in *United Wire* (the "New Jersey statute") concerned the rates actually charged by hospitals

for certain procedures and the discounts given by the hospitals to particular categories of payors. The New Jersey statute prospectively set hospital rates on the basis of DRGs and required hospitals to include in the DRG rate a charge to cover bad debt expenses and the cost of uncompensated care provided to the indigent. The New Jersey statute also provided DRG discounts to high volume plans and plans with open enrollment. At the same time, the New Jersey statute authorized hospitals to charge patients who did not belong to such plans an increased rate to allow hospitals to recover the income lost by virtue of the discounts.

In contrast, the 9% assessment has nothing to do with hospital rate reimbursement. The purposes of the 9% assessment are to compel HMOs to enroll Medicaid recipients and to raise revenue for the State. The statute attempts to accomplish this goal by imposing a penalty, calculated at 9% of its aggregate hospitalization cost, on HMOs that fail to comply with the State's Medicaid objectives. That the 9% assessment is connected to the cost of hospitalization is purely arbitrary. The legislature could have selected any other fixed or variable yardstick to determine the amount to be paid by HMOs that were unable to comply with the State's Medicaid objectives.

Thus, the 9% assessment differs in many critical respects from the hospital reimbursement scheme challenged in *United Wire*. First, unlike the *United Wire* surcharge which is added to the patient's hospital bill and is kept by the hospital, the 9% assessment does not increase the actual rate that HMOs pay hospitals. Rather, it is a separate charge that is imposed by the State on HMOs that fail to enroll a target number of Medicaid recipients. As such, the 9% assessment

has no effect on the rate an HMO pays a hospital for the cost of services provided to its subscribers. Second, unlike the surcharges at issue in *United Wire* that were specifically designed to reimburse hospitals for bad debts and uncompensated care, the 9% assessment does not function as a tool to reimburse hospitals. Indeed, the assessment produces no revenue whatsoever for the hospitals. Third, unlike payments made directly to hospitals pursuant to the New Jersey statute, the 9% assessment is paid by the HMOs into a statewide pool and deposited directly into the State's General Fund. Thus, the hospitals neither receive the funds nor act as a conduit for their transfer to the State. Lastly, unlike the *United Wire* payment scheme, the 9% assessment does not regulate the cost of hospital care. Indeed, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid patients.[6]

Thus, the petitioners' efforts to construct a conflict between the Third Circuit's decision in *United Wire* and the Second Circuit's decision in this case fall apart when applied to the 9% assessment. There simply is no conflict and, accordingly, no reason for this Court to grant certiorari on the question of whether the 9% assessment is preempted by ERISA.

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[6]Even if the statutes here were identical, there would not be a conflict requiring review. *United Wire* relied principally on the Second Circuit's decision in *Rebaldo v. Cuomo*, whose analysis has now been discredited by subsequent decisions of the Supreme Court and the Second Circuit. *See infra* at 20-22. Indeed, the Third Circuit appears to be retreating from its own decision. *See Travitz v. Northeast Department ILGWU Health and Welfare Fund*, 13 F.3d 704, 710 (3d Cir. 1994) (court declined to follow *United Wire* distinguishing the facts of that case from the one before it).

II. The Issues Presented by the 9% Assessment are Neither Matters of National Importance Nor Likely to Recur

The Second Circuit's decision preempting the 9% assessment will have no substantive effect beyond the confines of this particular case. The 9% assessment is nothing more than a narrowly tailored attempt by New York State to encourage HMOs to enroll Medicaid recipients by imposing a penalty on those that fail to achieve certain Medicaid targets. It does not regulate the cost of hospital care, nor does any money generated by it ever flow through the hospital system. Indeed, there are no cases currently pending that involve a similar assessment, nor have there been any reported decisions on the issue. Moreover, New York appears to be the only state with such an assessment.[7]

Petitioners nonetheless regale the Court with a "sky is falling" argument that all hospital and health care regulation throughout the nation will come to an immediate halt if the Second Circuit's decision that the 9% assessment and other surcharges are preempted is allowed to stand. Even if petitioners' arguments as to the 11% and 13% surcharges were correct, they are inapplicable to the 9% assessment. The 9% assessment does not regulate either the cost of hospital care or the cost of goods used by hospitals. As such, its preemption will have no effect whatsoever on the ability of New York, or any other state, to regulate the operation of hospitals and the cost of hospital care.[8]

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[7]Although the State asserts that at least 22 other states have health care regulations similar to "one or more of the disputed surcharges" (State Petition at 14), it does not point to any state with a penalty like the one imposed here.

[8]Indeed, none of the many cases cited by petitioners which purport to involve similar hospital reimbursement schemes involve anything like the 9% assessment at issue in this case.

Similarly, the Second Circuit's decision preempting the 9% assessment will not impede federal cost containment policies or the ability of states to enact comprehensive all-payor hospital cost containment legislation. (*See* HANYS Petition at 18). As previously discussed, the 9% assessment is tied to the cost of hospitalization only because of an arbitrary decision by the State to use that mechanism as a way to impose a penalty on HMOs that do not enroll the target number of Medicaid recipients. Neither the imposition nor the collection of the penalty itself is related to the cost of hospitalization in any substantive fashion. Indeed, if the 9% assessment was removed entirely from New York's hospital rate regulation scheme, there would be no effect on hospitals.

Lastly, the decision of the lower court that the 9% assessment is preempted by ERISA is simply not ripe for review at this juncture. As noted by the State, the nation is on the verge of health care reform (*see* State Petition at 16). As part of the legislative process, Congress will have every opportunity to revise or amend the scope of ERISA's preemption provision if it so chooses. Thus, the pendency of national healtn care reform argues in favor of this Court deferring review of the Second Circuit's 9%-preemption decision.[9]

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[9]Moreover, at the request of petitioners New York State and HANYS, Congress enacted legislation that would cause businesses to lose their ability to deduct the cost of their health care coverage if their insurer, or HMO, does not reimburse hospitals in accordance with New York State's hospital reimbursement scheme. Section 13442 of the Omnibus Budget Reconciliation Act of 1993, 26 U.S.C. § 162(n). Thus, contrary to petitioners' claims, a decision to deny certiorari will have little immediate impact on hospitals or the State.

III. The Second Circuit Correctly Held That The 9% Assessment is Preempted by ERISA

A. The 9% Assessment Relates to Employee Benefit Plans

The Second Circuit correctly interpreted governing Supreme Court precedent, which emphasizes the broad nature of ERISA's preemptive sweep, in concluding that the 9% assessment is preempted by ERISA. As noted by the Second Circuit and as this Court has long emphasized, a law relates to an employee benefit plan for the purposes of preemption if "it has a connection with or reference to such a plan". *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 (1992). Under the "broad common-sense meaning" attributed to this phrase by the Supreme Court, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), "a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans or the effect is only indirect." *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139 (1990).

Despite the Supreme Court's broad interpretation of ERISA's preemptive reach, petitioners nonetheless assert that the Second Circuit wrongly concluded that the 9% assessment does not sufficiently "relate to" an employee benefit plan to warrant preemption. Petitioners fail to acknowledge, however, that the economic impact experienced by the HMOs is not merely an incidental or indirect cost of doing business. In essence, the cost of the 9% assessment had to be large enough to persuade the HMOs that it was not economically feasible to refuse to enroll the desired number of Medicaid patients. Thus, Judge Freeh found that the effect was intended to be and was in fact substantial. (A-73).

The HMOs submitted substantial evidence of this impact, which was relied on by the District Court and the Second Circuit in arriving at their conclusion that the economic impact of the 9% assessment on employee benefit plans was substantial. For example, in the 1993-1994 fiscal year, the 9% assessment was intended to raise approximately $30 million from HMOs and the employee benefit plans they serve. (JA 1733). Thus, HMOs were required to pay millions of dollars to the State. The HMOs themselves simply cannot absorb this cost. (JA 1554, ¶ 23). Because the reserves maintained by HMOs cannot be used to defray administrative expenses like the 9% assessment, HMOs have no choice but to pass the cost of the assessment on to the ERISA plans.

Faced with the threat of increased fees and/or reduced benefits, an ERISA plan cannot, as suggested by petitioner HANYS (*see* HANYS Petition at 20-21), merely switch to an alternative health insurance system. HMOs do not simply reimburse independent providers of care; HMOs provide access to care. Accordingly, an ERISA plan cannot select alternative coverage without, in many cases, disrupting the care that is being provided to its employees. Nor can employee benefit plans simply opt to avoid the assessment by eliminating HMOs as a health care option. *See* N.Y. Pub. Health Law § 4403 (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.15 (1992) (employers with more than 25 employees must offer HMOs as a health care option).

Moreover, because the 9% assessment forces ERISA plans to either pay increased plan costs to provide the same level of benefits or reduce plan benefits to offset the cost of the assessment, the Second Circuit correctly found that the

9% assessment sufficiently "interfere[d] with the choices that ERISA plans make for health care coverage" as to constitute a "connection with" ERISA plans. (A-22-23). The assessment thus imposes precisely the kind of burden on plan administration that ERISA was designed to avoid. For example, the Second Circuit relied on *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991), in which a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. In *E-Systems*, the Fifth Circuit held that

> The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation.

E-Systems, Inc., 929 F.2d at 1103. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (provision of New York labor law which required particular employers to pay employees certain benefits was preempted by ERISA because "private parties, not the Government, control the level of benefits" under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 [1981]), *cert. denied*, 496 U.S. 912 (1990).[10]

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[10]The case at hand is very different from *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), relied on by petitioners. In *Mackey*, the Supreme Court based its decision that a state law permitting the garnishment of welfare benefits was not preempted by ERISA on the presence of a separate provision in ERISA which expressly forbid garnishment of a participant's *pension* benefits, rather than on an analysis of the statute's economic impact on the plan. The Court held that once Congress was aware that ERISA plan benefits could be attached or garnished, its decision to remain silent regarding *welfare* plan benefits "acknowledged and accepted the practice, rather than prohibiting it." 486 U.S. at 837 (quoting *Alessi*, 451 U.S. at 516).

In addition, although not raised by petitioners, it is important to note that the 9% assessment cannot function irrespective of ERISA plans. As a general matter, the Second Circuit noted that eighty-eight percent of non-elderly Americans receive some form of private health care coverage through ERISA plans. (A-6). The vast majority of the HMOs' subscribers are beneficiaries of ERISA plans.

Further evidence that ERISA was intended to preempt surcharges such as the 9% is found in President Clinton's proposed Health Security Plan. In that plan, the President expressly provides that the new plan will *modify* ERISA's current preemption provision to, *inter alia*, permit states more flexibility in regulating health care. White House Domestic Policy Council, Working Group Draft (September 7, 1993), *reprinted in The President's Health Security Plan—The Complete Draft Report of the White House Domestic Policy Council* 80 (Times Books) (1993). Had the President and his health care council believed that such laws were not already preempted by ERISA, no such modification provision would have been necessary.

B. The Second Circuit Was Correct in Refusing to Follow *United Wire* and *Rebaldo*

The Second Circuit also properly rejected petitioners' reliance on *United Wire* and *Rebaldo*. As noted by the Second Circuit, the principle that to be preempted a state law must "purport to regulate" an ERISA plan, emanating from *Rebaldo v. Cuomo*, has now been expressly rejected by the Supreme Court. (A-21).[11] Because the *United Wire* deci-

[11]In *Rebaldo*, the Second Circuit held that regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals was not preempted by ERISA because the law did not purport to regulate the terms and conditions of employee benefit plans. *Rebaldo*, 749 F.2d at 137.

sion relied heavily on *Rebaldo* and too narrowly interpreted ERISA's preemption clause, the Second Circuit declined to follow it.

In 1990, the Supreme Court issued two decisions which establish that in order to be preempted by ERISA, a state law need not make express reference to nor purport to regulate an ERISA plan. In the first, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), this Court held that its earlier ERISA preemption decision of *Shaw v. Delta Air Lines*, 463 U.S. 85, 95 (1983), which held that a law related to an employee welfare plan and is preempted by ERISA if it has "a connection with or reference to such a plan," was not intended to mean that only those state laws "specifically designed to affect employee benefit plans" or concerning the subject matter covered by ERISA, are preempted by ERISA. Indeed, the Supreme Court further elaborated on this issue a short time later in its decision in *Ingersoll-Rand v. McClendon*. In *Ingersoll-Rand*, the Court held that a law relates to a benefit plan for preemption purposes "even if the law is not specifically designed to affect such plans, or the effect is only indirect." 498 U.S. at 139.

Following those decisions, the Second Circuit shifted gears and held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2d Cir. 1992). In the District Court's decision here, Judge Freeh adopted this analysis and concluded that the 9% assessment is preempted by ERISA. (A-69, 75).

The Second Circuit here correctly adopted Judge Freeh's determination that *Rebaldo*'s fundamental premise, rejected by the Supreme Court (and later Second Circuit precedent), poisoned that decision's entire analysis. (A-21). Thus, the

Second Circuit properly held that petitioners' reliance on *Rebaldo* was misplaced and refused to follow the decision of *United Wire* which relied on it. The Second Circuit held instead that the surcharges satisfied the less stringent "connection with" standard of *Ingersoll-Rand*. (A-22).[12]

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[12]There is no reason for this Court to review the Second Circuit's decision that the 9% assessment is not saved from preemption by the insurance savings clause. First, petitioners did not argue below and do not appear to be arguing here that the 9% assessment is saved from preemption. Second, and most importantly, the 9% assessment is directed solely at HMOs. As the Second Circuit held, New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Public Health Law § 4411 (McKinney 1985). Thus, the court correctly held that the 9% assessment does not fall within the scope of the savings clause because HMOs do not engage in the business of insurance. (A-26-27 n.5).

Conclusion

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

Dated: Albany, New York
April 8, 1994

Respectfully submitted,

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No. 93-1415

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

v.

THE TRAVELERS INSURANCE COMPANY, HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIAN'S HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONER

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Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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REPLY BRIEF FOR PETITIONER

Petitioner Hospital Association of New York State ("HANYS") respectfully submits this Brief in reply to the

Brief In Opposition submitted on behalf of The Travelers Insurance Company, Health Insurance Association of America, and the other Respondents joining in that Brief. No reply is made to the Brief In Opposition submitted on behalf of the New York State Health Maintenance Organization Conference and the other health maintenance organizations joining in that Brief.

I. CONFLICT BETWEEN CIRCUITS

Although the Second Circuit expressly declined to follow the Third Circuit's reasoning in *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*,[1] (A-24 n.3; A-53 n.2), Respondents assert that there is no conflict between the two cases, relying on two frivolous arguments.

Respondents assert that there is no conflict because the Third Circuit might have decided *United Wire* differently had it known that the Second Circuit would subsequently abrogate the rationale of *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). *Rebaldo*, however, was neither dispositive nor controlling in *United Wire*; the Third Circuit subscribed to *Rebaldo's* economic impact analysis simply because it believed that *Rebaldo's* analysis made eminent sense. The Third Circuit specifically characterized the reasoning in *Rebaldo* as "persuasive" (995 F.2d at 1194), and stated that the touchstone of *Rebaldo's* analysis was that the *Rebaldo* Court was " 'dealing . . . with a generally applicable statute that makes no reference to, [and] functions irrespective of, the existence of an ERISA plan,' . . . and that affects such plans only by increasing their costs of doing business." *Id.* at 1195. The Third Circuit further emphasized that it was "the absence of a direct nexus to ERISA plans and the limited nature of the statute's impact on such plans that put the pricing regulation in *Rebaldo* beyond the scope of § 514 preemption." *Id.* The

[1] 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993).

fact that the Second Circuit decided not to follow *Rebaldo* does not mean that the Third Circuit would abandon the reasoning that it found so persuasive.

Respondents also argue that the cases are factually dissimilar because a New York State official observed in the Record below that in light of Blue Cross' open enrollment and community rating policies, the 13% differential helps "level the playing field," whereas no such comment was made by a New Jersey official in *United Wire*.[2] According to Respondents, if this observation had been made in *United Wire*, the Third Circuit may have found in favor of ERISA preemption.[3] Whether or not a similar statement can be found in the Record in *United Wire* is unknown, but also irrelevant. The two decisions are irreconcilable because they reached diametrically opposite results on laws that operate in virtually an identical manner. This remark is a mere distraction; the Second and Third Circuits reached opposite results because of a fundamental difference over the legal significance under ERISA of a state law's economic impact on ERISA plans.

II. IMPORTANCE OF THE DECISION

The provisions of New York's Public Health Law which create a 13% differential in rates among certain payors is a law of general application which operates without regard to a patient's ERISA coverage.[4] ERISA plans

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[2] In making this point, Respondents incorrectly attribute to New York officials a statement that the 13% differential plus the 11% assessment will make purchasers of health insurance "think twice as hard" about purchasing commercial insurance. *See* Brief In Opposition, at 15. In fact, this statement was made by a Blue Cross official and can hardly be the deciding basis for summary judgment in a matter of such import and magnitude. *See* page 821 of Joint Appendix filed with the U.S. Court of Appeals for the Second Circuit.

[3] Although Respondents vigorously attempt to distinguish the two cases, their briefs below relied heavily on the district court's decision in *United Wire*.

[4] Under the two provisions that make up the differential, New York Public Health Law sections 2807-c(1)(a) and 2807-c(1)(b),

enjoy the benefits of strict State control of hospital rates and costs, and retain the right to decide with whom, if anyone, to insure and, based upon that choice, what portion of the mandated rates to pay. Nevertheless, the Second Circuit held that ERISA preempts the 13% differential, a law of general application, because of its indirect economic impact on ERISA plans. Respondents argue that certiorari should not be granted because the Second Circuit decision is narrow, limited only to the differentials at issue, and does not "undermine a state's ability to regulate hospital rates." Brief In Opposition, at 13.

The contention that the Second Circuit's decision does not call into question a state's ability to regulate hospital rates is simply incorrect. The decision is having just that effect already in subsequent district court decisions. It is logical that if ERISA preempts the 13% differential because of its economic impact on plans, it may also preempt any law that creates a similar economic impact, even where the law, as here, is one of general application. Based on the Second Circuit's decision below, ERISA may preempt a state's right to set rates at all, since any mandatory rates, like the 13% differential, will have an economic impact on ERISA plans. Similarly, despite their denials, Respondents have not explained why ERISA would not preempt an array of other state laws, such as minimum staffing and medical waste disposal laws, or labor laws, whose costs are imposed on hospitals, reflected in their rates, and then indirectly passed on to all payors, including ERISA plans.[5]

ERISA plans are free to purchase Blue Cross, to purchase commercial insurance or to self-insure. The DRG rate under section 2807-c(1)(b) is 113% of the DRG rate under section 2807-c(1)(a), whether or not coverage is provided through an ERISA plan, a non-ERISA plan, or an individual policy. Hospitals also bill that same rate to patients who are covered under a variety of arrangements which do not provide ERISA coverage, such as a workers' compensation policy and "no-fault" insurance.

[5] This effect can be seen from another standpoint. Blue Cross plans operate in an entirely different legal environment from com-

Indeed, not only are plaintiffs in other litigations attributing a more expansive reading to the Second Circuit's decision, but various district courts within the Circuit are reading the Second Circuit's decision below as mandating that other state health care statutes are preempted because they result in an economic impact upon ERISA plans. In *New England Health Care Employees v. Mount Sinai Hospital*, No. 2:92 CV 1012 (JAC) (D. Conn.) (Feb. 24, 1994), the Connecticut District Court held that, based on the Second Circuit's decision below, ERISA preempts Connecticut's method of compensating hospitals for care rendered to the indigent, uninsured and underinsured based upon the statute's indirect economic impact on ERISA plans. Similarly, in *New York State Health Maintenance Organization Conference v. Curiale*, 93 Civ. 1298 (MBM) (S.D.N.Y.) (Feb. 25, 1994), the court held that the Second Circuit's decision below requires a finding that ERISA preempts a New York health insurance pooling regulation which was designed to allocate the costs of high-risk individuals among all third-party payors, regard-

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mercial insurers and self-insured plans. There will always be a difference in premiums among payors, or between premiums and the costs of self-insurance, because there is no uniformity in the regulation or operation of Blue Cross versus commercial or self-insurance. In New York, Blue Cross plans are non-profit, while commercial insurers are proprietary. Blue Cross rates must be approved by the Superintendent of Insurance after public hearings, (N.Y. INS. LAW § 4308 (McKinney 1985 & Supp. 1994)), unlike the rates of commercial insurers. Blue Cross plans also have traditionally provided community rating and open enrollment. These unique requirements create costs to Blue Cross plans that are reflected in premiums, which are not costs experienced by commercial insurers or self-insured plans. Thus, while the 13% differential is a cost incurred by patients of commercially-insured or self-insured plans, and not a cost of patients insured by Blue Cross plans, there are myriad costs imposed by statute experienced by Blue Cross plans that are not experienced by those other payors. To single out just one difference among costs experienced by one payor and not the other payors to argue that this difference might (not does) affect plan decisions, while ignoring all of the other cost differences that go the other way, is simplistic.

less of ERISA status.[6] Thus, whatever narrow reading Respondents want to give the Second Circuit opinion, their interpretation is not shared by courts being asked to apply its reasoning and holding.

Nor does the federal Omnibus Budget Reconciliation Act of 1993 (the "Budget Act")[7] result in the Petition's seeking "a mere advisory opinion." Brief In Opposition, at 3. While hospitals presently continue to receive amounts attributable to the 13% differential from Respondents, this occurrence is obviously the result of the Second Circuit's having stayed its mandate pending the petition for a writ of certiorari.

The Budget Act, designed specifically to deal on a temporary basis with the District Court decision below, added section 162(n) to the Internal Revenue Code to prohibit employers from deducting contributions to health plans for services between February 2, 1993 (the day before the District Court rendered its decision) and May 12, 1995, unless such health plans pay, *inter alia*, the 13% differential. This temporary tax incentive, however, does not moot the Second Circuit's ruling on the 13% differential because there nevertheless will be a substantial patient population that is unaffected by this amendment.

First, section 162(n) sunsets on May 12, 1995. There is no remedial statute in place that will provide a tax incentive next year for employers to contribute to health plans that pay the 13% differential. Second, even with section 162(n) in place, hospitals will still suffer eco-

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[6] In addition to these cases described above, several pending actions involve challenges to other components of a state's hospital reimbursement system. *See, e.g., Trustees of & the Pension Hospitalization Benefit Plan v. Cuomo*, 92 Civ. 5589 (E.D.N.Y.) (challenging New York's method of funding bad debt and charity care); *Connecticut Gen. Life Ins. Co. v. Cuomo*, No. 93-3648 (S.D.N.Y.) (challenging the hospitals' practice of balance billing).

[7] Pub. L. No. 103-66, § 13442, 107 Stat. 312, 568 (1993) (codified at 26 U.S.C.A. § 162(n) (West Supp. 1994)).

nomic losses as a result of the decision below. Section 162(n) does not require that ERISA plans pay the 13% differential until the law sunsets. Whether a plan does so is a voluntary decision, influenced only in part by the tax status of the employer. Many employers simply may not require a tax deduction for their contributions, such as tax-exempt employers or employers showing a loss. Furthermore, notwithstanding the tax deduction to employers, ERISA plan trustees have their own fiduciary responsibilities to their plans, not to the employer. Thus, certain trustees have already taken the position that under the fiduciary provisions of ERISA, they cannot pay the 13% differential.[8] In fact, in another action pending in the Second Circuit, ERISA plans have amended their complaint to join the U.S. Secretary of the Treasury and the Commissioner of Internal Revenue, challenging the constitutionality of section 162(n). *Connecticut Gen. Life Ins. Co. v. Cuomo*, 93-3648 (S.D.N.Y.).[9]

III. FEHBA

In its petition for a writ of certiorari, Petitioner HANYS explained that the same faulty reasoning that led to the Second Circuit's holding under ERISA has driven its holding under the Federal Employees Health Benefits Act ("FEHBA"), (5 U.S.C. § 8901, *et seq.* (1988 & Supp.

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[8] In *Trustees of & the Pension Hospitalization Benefit Plan v. Cuomo, supra*, plaintiffs contend that paying the 13% differential violates the trustees' fiduciary responsibilities.

[9] Respondents also state that New York's recent extension of the 13% differential moots the issues in this action. The Legislature, however, has merely moved back the earlier sunset date of December 31, 1993. 1993 N.Y. Laws ch. 731, §§ 35, 76(5). It has not "reenacted" that provision in some manner that could render this controversy moot. Respondents have not suggested here or elsewhere that they do not consider the Second Circuit judgment and order to have a continuing binding effect upon Petitioners. Nor have Respondents suggested that without the 11% and 9% assessments, the 13% differential would not have a sufficient economic impact on ERISA plans to avoid preemption.

IV 1992)). Should this Court determine to grant the petition on the ERISA-related issues, its decision almost certainly will be of significance to the proper determination of the FEHBA preemption issue. Accordingly, certiorari should be granted on the FEHBA issue as well, so that the results for ERISA and FEHBA preemption are consistent.

Respondents' contention that the Second Circuit's FEHBA holding is "solidly grounded" in (1) the language of the statute; (2) its legislative history; and (3) a reasonable administrative interpretation, (Brief In Opposition, at 22), is erroneous on each point. The statute clearly speaks only to taxes or fees imposed with respect to a payment from the FEHB Fund, and not to the method by which the amount of the payment is calculated. The legislative history supports that the preemption relates solely to premium taxes, and the administrative agency interpretation is inconsistent with the agency's own duly promulated regulations.

CONCLUSION

Based on the foregoing, the Petition of the Hospital Association of New York State for a writ of certiorari should be granted.

Respectfully submitted,

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Nos. 93-1408, 93-1414 and 93-1415

In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

MARIO M. CUOMO, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

HOSPITAL ASSOCIATION OF NEW YORK, PETITIONER

v.

TRAVELERS INSURANCE CO., ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

In three related statutes, New York State law imposes different surcharges on the rates hospitals charge, depending on whether the charges are paid by commercial insurers, health maintenance organizations, self-insured funds, or other specified payors. The questions presented are:

1. Whether the surcharges, which apply to hospital care regardless of whether it is provided pursuant to an Employee Retirement Income Security Act (ERISA) plan, are preempted by ERISA insofar as the hospital charges are covered by an ERISA plan.

2. Whether the surcharges are preempted by the Federal Employees Health Benefit Act (FEHBA), insofar as they apply to hospital care covered by a FEHBA plan.

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In the Supreme Court of the United States

OCTOBER TERM, 1994

No. 93-1408

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

No. 93-1414

MARIO M. CUOMO, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

No. 93-1415

HOSPITAL ASSOCIATION OF NEW YORK, PETITIONER

v.

TRAVELERS INSURANCE CO., ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. New York State has a "comprehensive statutory scheme for the regulation of in-patient hospital rates." Pet. App. A64-A65.[1] For each of 794 diagnostic related groups (DRGs), a uniform rate is set that reflects the average cost of treating a patient with a particular diagnosed condition, adjusted for each hospital to reflect factors such as its operating costs, capital costs, malpractice costs, and bad debt and charity care costs. The rate for a particular DRG thus varies from hospital to hospital. In general, patients entering a hospital are assigned a DRG according to their condition, and are billed at the DRG rate for that particular hospital, rather than for the actual cost of treatment. *Id.* at A65.

In 1988 and 1992, the New York legislature enacted legislation that required that hospital rates be calculated according to not only the DRG rate for the patient and hospital, but also the party paying for the services. The legislation prescribed three surcharges to be added to hospital rates:

First, a 13% surcharge was imposed on all hospital bills paid by a commercial insurer, by "a self-insured fund" that directly reimburses hospitals, or by any of a number of specialized payment schemes, including workers' compensation, volunteer firefighters' and ambulance workers' benefits, and no-fault motor vehicle insurance. N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993) (Pet. App. A102). The surcharge is paid to the hospital and retained by it. Having been renewed once, the surcharge, along with the balance of New York's hospital cost regulations, will expire on December 31, 1995, unless it is extended. 1993 N.Y. Laws, ch. 731, § 35.

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[1] All references to "Pet. App." are to the appendix to the petition for a writ of certiorari in No. 93-1414.

Second, an additional surcharge of 11% was imposed on hospital bills paid by commercial insurers, raising the total surcharge for such payors to 24%. 1992 N.Y. Laws, ch. 55 § 348 (Pet. App. A104). That surcharge was to be paid to the hospital, which was then to pay it into the State's general fund. The 11% surcharge was imposed for a one-year period that ended on March 31, 1993. *Ibid.*

Third, rates for services rendered to members of health maintenance organizations (HMOs) were surcharged 0% to 9%, depending on how close the particular HMO came to meeting its target for enrollment of Medicaid recipients. N.Y. Pub. Health Law § 2807-c2-a(a)-(e) (McKinney 1993) (Pet. App. A106-A113). The 0% to 9% surcharge was paid by the HMO directly into a statewide pool, and then into the state treasury. N.Y. Pub. Health Law § 2807-c2-a(c) (McKinney 1993) (Pet. App. A111). Under current law, the surcharge on HMOs will expire on December 31, 1995, unless it is extended. 1993 N.Y. Laws, ch. 731, § 35.

Some hospital bills are not subject to any surcharge. Services covered by Medicaid or a Blue Cross/Blue Shield plan (the Blues) are billed at the DRG rate without a surcharge. N.Y. Pub. Health Law § 2807-c(1)(a) (McKinney 1993) (Pet. App. A101). Services rendered to all other patients, including patients who pay their own bills or are covered by self-insured funds or commercial insurers that reimburse the patient rather than the hospital, are subject to the hospital's own charges (not the DRG rate), with a statutory limit higher than that charged to commercial insurers. N.Y. Pub. Health Law § 2807-c(1)(c) (McKinney 1993) (Pet. App. A103).

The purpose of the 13% surcharge is "to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers" by making the Blues—which are required by the State to engage in open enrollment, making them the "insurer of last resort" for high-risk individuals, see Pet. App. A28—more competitive with com-

mercial insurers. The 11% surcharge had a similar purpose, and also was designed to increase state revenues. By comparison, "the primary purpose of the 9% assessment [is] to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program." *Id.* at A7-A8.

2. a. This case principally presents the question whether the 13%, 11%, and 9% surcharges are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* ERISA generally governs employee benefit plans, see 29 U.S.C. 1003(a), including any employee welfare benefit plan "established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits." ERISA § 3 (1), 29 U.S.C. 1002(1). ERISA plans pay for a large percentage of hospital bills in New York State. Pet. App. A6. "ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills * * *; (3) subscription to a health maintenance organization * * *; and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans." Pet. App. A6-A7. Thus, ERISA plans that provide hospitalization benefits either are themselves payors of hospital bills or are purchasers of hospitalization coverage from commercial insurers or other payors.

The primary preemption provision of ERISA is Section 514(a), 29 U.S.C. 1144(a). It states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. The insurance savings clause of ERISA, § 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), however, limits the reach of the preemption clause. The savings clause states that, except as provided in the "deemer clause," described

below, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance." See App., *infra*, 1a. Finally, what has come to be known as the "deemer clause," ERISA § 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), makes a distinction between "an insurance company or other insurer * * * engaged in the business of insurance," to which the saving clause applies, and "an employee benefit plan," which shall not be "deemed" to be an insurance company or engaged in the business of insurance for preemption purposes. See App., *infra*, 1a. Thus, state regulation of the business of insurance is not preempted except insofar as it applies to employee benefit plans themselves. See *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61-63 (1990).

b. This case also concerns whether the 13% and 11% surcharges are preempted by the FEHBA. Under 5 U.S.C. 8909(a) (Supp. IV 1992), an "Employees Health Benefits Fund which is administered by the Office of Personnel Management [OPM]" is established in the Treasury, to receive government and federal employee contributions for medical benefits. OPM in turn contracts with various carriers to offer health benefit plans that pay the cost of medical services for covered federal employees. With respect to the experience-rated health benefit plans at issue in this case, the carrier first pays for a covered medical service and is then reimbursed by withdrawing from the Employees Health Benefits Fund in the Treasury. Pet. App. A14-A15 & n.3.

FEHBA's primary preemption provision was added in 1990. See Pub. L. No. 101-508, Tit. VII, § 7002(c), 104 Stat 1388-330, codified at 5 U.S.C. 8909(f) (Supp. IV 1992). As relevant here, it provides that "[n]o tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved [FEHBA] health benefits plan, * * * with respect to any payment made from the Fund." 5 U.S.C. 8909(f)(1) (Supp. IV 1992).

On July 29, 1992, the New York Department of Health asked OPM for a written opinion regarding the preemptive effect of Section 8909(f). C.A. App. 1545. On August 25, 1992, OPM replied that "the assessments imposed by the State of New York on the hospital bills paid by FEHB plans * * * are preempted by Federal law" because they "impose[] payment obligations on insurers with respect to payments to the insurer from the FEHB Fund." C.A. App. 1546.

3. In two actions later consolidated in the federal district court, the respondent insurance companies and their trade association sought to invalidate and enjoin enforcement of the three surcharges on grounds that the surcharges are preempted by ERISA and FEHBA. The other respondents (New York State Health Maintenance Organization Conference and several HMOs) intervened in support of the insurers, and the New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York intervened on behalf of New York State. On cross-motions for summary judgment, the district court held, as pertinent here, that ERISA preempts all three surcharges, and it enjoined their enforcement "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." Pet. App. A89-A90. The district court also held that FEHBA preempts the 13% and 11% surcharges. *Id.* at A86.

4. a. The court of appeals affirmed the district court's ruling that ERISA preempts all three surcharges. The court held that, although the surcharge statutes "do not refer to ERISA plans," Pet. App. A22, they "relate to" ERISA plans within the meaning of Section 514(a) because they "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand* [*Co.* v. *McClendon*, 498 U.S. 133 (1990)]." *Ibid.* The court found the requisite connection in the fact that, because the surcharges were designed to increase hospital costs for patients not covered by the Blues, "the surcharges purposely

interfere with the choices that ERISA plans make for health care coverage," *ibid.*, and force ERISA plans "to increase either plan costs or reduce plan benefits," *id.* at A23. The court rejected the argument that indirect economic impact alone does not suffice to justify a finding of preemption. *Id.* at A23-A24. Thus, it concluded that the "three surcharges 'relate to' ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration." *Id.* at A24.

The court also ruled that the 11% and 13% surcharges are not saved from preemption under Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), as laws "which regulate[] insurance." It held that the surcharges are not insurance laws as a matter of "common-sense" because they regulate hospital rates and are not directed at the insurance industry. Pet. App. A26-A27. The court rejected the argument that laws "designed to affect the insurance marketplace by giving the Blues a competitive advantage over * * * other players in the marketplace" amount to regulation of the "business of insurance" within the meaning of ERISA's savings clause. *Id.* at A27.

The court reached the same conclusion after applying the three traditional factors for determining whether a state insurance law is protected by the McCarran-Ferguson Act, 15 U.S.C. 1012, which this Court has found applicable under ERISA's insurance savings clause as well. See *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48-49 (1987). The court agreed with petitioners that the first factor—"risk spreading"—supports the validity of the surcharges, because they spread risk by encouraging plans to shift to the Blues. Pet. App. A28. In the court's view, however, the second factor is not satisfied because the surcharges "do not regulate any practice that is integral to the insurer-insured relationship." *Ibid.* The court reasoned that the surcharges do not directly affect the "terms, conditions or scope of coverage in commercial

insurance contracts," and "relate only to the contractual obligations between hospitals and insurers or insureds," rather than the relationship between the insurers and insureds. *Id.* at A29. Finally, the court held that the third factor is not satisfied, reasoning that the surcharges are not " limited to entities within the insurance industry," because the surcharges affect non-insurance entities such as "the State, hospitals, patients, HMOs, and self-insured funds." *Ibid.*

In two footnotes, the court approved the district court's holding that the 9% surcharge affecting only HMOs is not saved because HMOs do not engage in the business of insurance "as a matter of law." Pet. App. A26 n.5, A29 n.6. In reaching that conclusion, the court specifically rejected the position of the Secretary of Labor as amicus curiae that, regardless of how HMOs may be treated for other purposes, they were, in the context of this case, "person[s]" subject to State laws "which regulate insurance," within the meaning of the insurance savings clause. *Id.* at A26 n.5.[2]

b. On the FEHBA issue, the court of appeals held that "[b]ecause payments from the [FEHBA] Fund are directly affected by what the hospitals charge for their services, and because the surcharges increase the amounts carriers draw from the Fund, the surcharges are clearly imposed 'with

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[2] The district court had stayed its judgment as to the 13% surcharge and ordered that funds from the 9% and 11% surcharges be paid into escrow. Pet. App. A98. The court of appeals stayed its mandate pending the filing and disposition of petitions for writs of certiorari. HANYS Reply Br. 6. Congress amended the Internal Revenue Code to provide that employers will lose certain plan-related tax deductions if their plans do not pay the New York surcharges due for hospital services rendered between February 2, 1993, and May 12, 1995. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13442, 107 Stat. 568, amending 26 U.S.C. 162(n). That amendment apparently motivated many providers of health coverage to continue paying the surcharges. See Travelers Br. in Opp'n 2.

respect to . . . payment[s] made from the Fund.' " Pet. App. A15. The court also noted that, "[e]ven if [it] agreed that the language of § 8909(f)(1) is ambiguous," it would still "defer to OPM's interpretation of its own regulation" and hold the surcharges preempted. *Id.* at A17. The court therefore affirmed the district court's holding that FEHBA preempts the 11% and 13% surcharges, insofar as they apply to rates for services covered by FEHBA. *Ibid.*

DISCUSSION

The court of appeals held that the surcharges imposed under New York's comprehensive regulation of in-patient hospital charges "relate to" ERISA plans and are not preserved from preemption by ERISA's insurance savings clause. The holding that the surcharges are preempted creates a conflict with a decision of the Third Circuit that a similar New Jersey scheme that sets hospital rates in part on the basis of the nature of the payor is not preempted by ERISA. In our view, the Second Circuit's decision erroneously expands ERISA's preemption provisions and, as a consequence, improperly confers an immunity for ERISA plans from generally applicable state laws that have only an indirect economic effect on ERISA plans. The court of appeals' decision is of particular importance, because it imposes unwarranted limits on the ability of the States to experiment with a variety of approaches to regulate the health care market in order to control costs and ensure that health care coverage is widely available. Further review is therefore warranted.

The court of appeals also held that New York's surcharges are preempted by FEHBA. That holding is correct and does not conflict with any decision of any other court of appeals. Because FEHBA's preemption provision differs substantially from ERISA's preemption provision, review of the court of appeals' FEHBA holding would not illuminate the ERISA

issues in this case, but would instead serve to add additional and unnecessary complication to what is already a highly complex case. Accordingly, further review of the court's FEHBA preemption holding is not warranted.

1. The Second Circuit's ruling that ERISA preempts the hospital surcharges imposed by New York law because they have an indirect economic impact on ERISA plans conflicts with the Third Circuit's decision in *United Wire, Metal & Mach. Health & Welfare Fund* v. *Morristown Memorial Hosp.*, 995 F.2d 1179, cert. denied, 114 S. Ct. 382 (1993). That case concerned New Jersey's hospital rate system, which—like that of New York—was based on a DRG rate, subject to various adjustments. Among the adjustments were some that raised the DRG rates for all payors and then redistributed the extra proceeds to hospitals that suffered losses because they provided uncompensated care or treated Medicare patients at lower payment rates. 995 F.2d at 1189. Other adjustments provided for a discount to high-volume health plans, such as Blue Cross, and for an 11% discount to plans with open enrollment. *Id.* at 1190.

The Third Circuit held that the payment scheme did not "relate to" an ERISA plan within the meaning of ERISA's preemption provision. The court reasoned that New Jersey's regulatory scheme was "a statute of general applicability that [was] designed to establish the prices to be paid for hospital services, which [did] not single out ERISA plans for special treatment, and which function[ed] without regard to the existence of such plans." 995 F.2d at 1192. Recognizing that the New Jersey statute could have increased the cost of hospital services for ERISA plan participants, the court viewed "[t]his effect [a]s no different in kind * * * from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs." *Id.* at 1193. The court further observed that the New Jersey statute did "not direct ERISA plans to structure their benefits or

conduct their internal affairs in any particular way," and did not impermissibly impede the interstate operation of ERISA plans, especially because the cost of hospital services varies from region to region in any event. *Ibid.* Under those circumstances, the court concluded that any "indirect ultimate effect of increasing plan costs" was insufficient to justify preemption. *Ibid.*; see *id.* at 1195.

Like the New Jersey statute at issue in *United Wire*, the New York statutes at issue in this case are laws "of general applicability": the various surcharges apply to categories of payors—*i.e.*, commercial insurers, HMOs, the Blues, self-insured plans, etc.—that are defined without regard to whether they provide health benefits for ERISA plans or participants in ERISA plans; petitioners assert —and respondents do not dispute—that each of the categories of payors in fact provides health benefits for both ERISA and non-ERISA plans and participants. See 93-1414 Pet. 4-5 & n.4; 93-1408 Pet. 14-15. The effect of the New York regulatory scheme, like that of the New Jersey scheme, is simply to vary the cost of hospital services for various payors. The New York statutes do not direct ERISA plans to provide any type or level of benefits. Nor do they impermissibly impede the interstate operation of ERISA plans, which—as the Third Circuit recognized—in any event must take into account widely varying hospital costs. In short, the New York statutes' effect on the ERISA plans at issue here is the "indirect ultimate effect of increasing plan costs." Yet, while the Third Circuit held that effect to be insufficient to warrant preemption in *United Wire*, the Second Circuit in this case reached the opposite conclusion.

Indeed, the Second Circuit recognized that its decision appeared to conflict with *United Wire*. Pet. App. A25 n.3. The court noted, however, that the Third Circuit had relied in part on a prior Second Circuit decision, *Rebaldo* v. *Cuomo*, 749 F.2d 133 (1984), cert. denied, 472 U.S. 1008 (1985), that the

Second Circuit in this case found to have been superseded by this Court's intervening decision in *Ingersoll Rand*.[3] Pet. App. A21, A25 n.3. The Second Circuit's repudiation of *Rebaldo* does not, however, mitigate the circuit conflict. To the contrary, the differing views of the two circuits about the continuing validity of the reasoning of *Rebaldo* simply mirror the difference between the circuits concerning whether a law of general applicability whose only effect on ERISA plans is on the cost of health services is preempted.

In any event, the Third Circuit made clear that it was relying on the reasoning of *Rebaldo*—not the fact that it continued to carry precedential weight in the Second Circuit. See 995 F.2d at 1193-1196. Indeed, each circuit has been quite express in acknowledging its disagreement with the other. The Third Circuit in *United Wire* expressly disagreed with the district court's decision in this case, see 995 F.2d at 1194 n.8—a decision whose reasoning was adopted in large part by the Second Circuit. And the Second Circuit expressed the view in this case that, aside from the disagreement about the continuing validity of *Rebaldo*, "[m]ore generally * * * the Third Circuit reads ERISA's preemption clause too narrowly." Pet. App. A25 n.3.[4]

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[3] *Rebaldo* upheld as not preempted by ERISA "a New York statute setting the rates that hospitals in that state had to charge patients, including those who were participants in self-insured employee benefit plans," in part on a theory that only statutes that "purport to regulate" ERISA plans are preempted. See *United Wire*, 995 F.2d at 1193. *Ingersoll-Rand* discredited that theory, see 498 U.S. at 141, as both the court below and the court in *United Wire* understood. Compare Pet. App. A21 with 995 F.2d at 1194-1195. The Second and Third Circuits, however, explicitly disagree on whether *Rebaldo*'s reasoning retains validity in other respects.

[4] The HMO respondents state (HMO Br. in Opp'n 14 n.6) that the Third Circuit "retreat[ed]" from *United Wire* in *Travitz* v. *Northeast Dep't ILGWU Health & Welfare Fund*, 13 F.3d 704, cert. denied, 114 S. Ct. 2165 (1994). *Travitz* had nothing to do with hospital cost regulations or, indeed, with regulation of the health care market. Instead, *Travitz* involved a state

2. The Third Circuit correctly rejected the proposition that state regulation that has an indirect and solely economic impact on ERISA plans is necessarily preempted. That conclusion follows from this Court's decision in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831 (1988), which repudiated the notion that the "substantial administrative burdens and costs" incurred by benefit plans subject to Georgia's general garnishment statute sufficed to bring the law within the "relate[s] to" language of Section 514(a) of ERISA. Similarly, in *Ingersoll-Rand*, on which the court of appeals purported to rely, this Court made clear that it was not "dealing * * * with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan," and that the statute at issue there did more than simply add an additional "cost" to the plan's "administrative burden." 498 U.S. at 139.

To the extent that they apply to commercial insurers or HMOs, the only effect that the surcharges in this case have on ERISA plans is both indirect (because the surcharges do not apply to plans themselves, but are generally applicable to insurers and other health carriers whose services are purchased both by ERISA plans and others) and solely economic (because the surcharges affect only the costs of services ERISA plans purchase, and thus do not dictate the type or nature of benefits that ERISA plans may or must offer to participants or regulate how an ERISA plan must be

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statute that precluded an individual injured in an automobile accident from recovering medical expenses from the tortfeasor if the individual was otherwise eligible to receive medical benefits from any "program, group contract, or other arrangement," 13 F.3d at 708, including an ERISA plan. The Third Circuit held the statute preempted by ERISA and, in a footnote, noted that *United Wire* was "inapposite on its facts" to the statute at issue in *Travitz*. 13 F.3d at 710 n.5. The footnote in *Travitz* does not suggest any alteration in the Third Circuit's position concerning whether hospital cost regulations of the sort at issue in this case are preempted by ERISA.

administered).[5] Insofar as the surcharges affect the rates charged by various health insurers and HMOs, they may influence plan choice. But there is a legally significant difference between a law that directly limits plan choice by mandating which benefits it must or must not purchase, *e.g.*, *Metropolitan Life Insur. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), and a law that has an indirect and solely economic impact on ERISA plans by affecting the price of services or commodities purchased both by ERISA plans and by others in the State. Because the surcharges at issue in this case fall into the latter category, they do not "relate to" the ERISA plans at issue in this case and they therefore are not preempted.[6]

3. We also disagree with the Second Circuit's conclusion that, if the 13% and 11% surcharges were found to "relate to" ERISA plans, they would not be saved by ERISA's insurance savings provision.[7] The Second Circuit believed that, as a

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[5] Application of the 13% surcharge to "self-insured funds" may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves, rather than to bills that are paid by commercial insurers, HMOs, or the Blues, who in turn contract with ERISA plans and others. This case, however, does not present those issues. None of the plaintiffs in this case is a self-insured fund, and none of them thus appears to have standing to challenge the application of the 13% surcharge to self-insured funds.

[6] In the court of appeals, the Secretary of Labor, appearing as amicus curiae, expressed the view that indirect economic impact is not a sufficient basis for ERISA preemption, but that the limitation of plan choice provided a sufficient connection to trigger preemption. He took the position that the surcharges "relate to" ERISA plans on that narrow ground, but that—except for self-insured ERISA plans, which are protected by the "deemer clause"—they are saved from preemption by the insurance savings clause. The discussion in text now represents the position of the Secretary.

[7] By virtue of ERISA's "deemer" clause, 29 U.S.C. 1144(b)(2)(B), see *FMC Corp.* v. *Holliday*, 498 U.S. at 61-65, the analysis of whether the 11% and 13% surcharges are saved with respect to self-funded ERISA plans

matter of common sense, the 11% and 13% surcharges regulate hospital rates, not the insurance industry. Pet. App. A26-A27. In our view, that view is mistaken. Both surcharges are "specifically directed" toward the insurance industry, *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. at 50, because the determination whether a payor must pay either surcharge turns wholly on the payor's status as a participant in the insurance marketplace, not on any factor concerning the nature of the hospital or of the medical service provided. In addition, the primary function of the two surcharges is to reduce the differential in insurance rates to account for the greater costs the Blues and some HMOs incur as a result, *inter alia*, of their open-enrollment and community-rating policies. That purpose is closely tied to the traditional function of insurance regulation: to affect the ways in which risks are spread. Accordingly, the 11% and 13% surcharges are reasonably viewed as insurance regulation.

The Second Circuit also erred in holding that the 11% and 13% surcharges satisfy only one of the three McCarran-Ferguson factors—"whether the practice has the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48. The court held that the surcharges do not satisfy the second McCarran-Ferguson factor because they "do not regulate any practice that is integral to the insurer-insured relationship." Pet. App. A28. Because the surcharges are premised on the open enrollment and community rating policies of the Blues and HMOs, they can be said to regulate the relationship between the insurer and the insured.

The Second Circuit finally held that the 11% and 13% surcharges fail to satisfy the third McCarran-Ferguson

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may be different from the analysis of whether they are saved as applied to other payors. Questions concerning the "deemer" clause, however, are not presented by this case, since no self-funded ERISA plan is among the plaintiffs.

factor because they "involve entities" that—in the court's view—are "beyond the insurance industry," such as "the State, hospitals, patients, HMOs, and self-insured funds." Pet. App. A29. The fact that the surcharges in some sense "involve" patients, hospitals, and the State, however, is of little significance. Insurance regulation generally is intended to have an effect on the customers of insurance companies—in this case, hospital patients—and to carry out the public policies of the State. So long as the amount of the surcharges is determined solely by the nature of the payor—*i.e.*, the payor's role in the insurance industry—the fact that hospitals collect the surcharges, and that the proceeds of the 13% surcharge are retained by hospitals, is not dispositive.

The court also erred in holding, as a matter of law, that HMOs are not part of the insurance industry for purposes of ERISA's insurance savings provision. See Pet. App. A26 n.5, A29 n.6. An HMO combines the function of an insurer (since for a set price it assumes the risk that a person will need medical care) and a provider of medical care (since it generally either provides the medical care itself or arranges for others to provide the care). Therefore, insofar as a State regulates the HMO in its role as insurer—which the 11% and 13% surcharges, by exempting HMOs, do, in the same way that they regulate the Blues—it is appropriate to view the surcharges as an aspect of the regulation of insurers for ERISA preemption purposes. That conclusion is buttressed by the language of the ERISA savings clause, which sweeps somewhat more broadly than the McCarran-Ferguson Act. The ERISA clause applies to "any person" subject to insurance regulation; by contrast, the McCarran-Ferguson Act's grant of authority to the States to regulate insurance is restricted to "[t]he business of insurance, and every person engaged therein." 15 U.S.C 1012(a). Especially in light of that difference, the court erred in concluding that the fact that the 11% and 13% surcharges have an effect on HMOs means that

the surcharges are not "limited to entities within the insurance business." Pet. App. A29.[8]

4. The issue on which the Second and Third Circuits are divided is of substantial importance. Since most health care is paid for through employee welfare benefit plans as a fringe benefit of employment, virtually every state regulation of a variable that operates in the health care marketplace would appear to satisfy the Second Circuit's "substantial economic impact" test, and therefore to be inapplicable to ERISA plans under the Second Circuit's decision in this case.[9] That consequence is already manifest in the Second Circuit, which recently held in *NYSA-ILA Medical & Clinical Servs. Fund* v. *Axelrod*, 27 F.3d 823 (1994), that a labor-management ERISA-covered fund that operates clinics for participating union members did not have to pay a generally applicable—if "de minimis," see 27 F.3d at 828—0.6% assessment on hospital revenues. Relying on the decision in this case, see *id.* at 827, 828, the court reasoned that because the assessment "targets only the health care industry," which "by definition" is "the realm where ERISA welfare plans must operate, the

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[8] Because the court of appeals found—incorrectly, in our view—that HMOs "do not engage in the 'business of insurance' as a matter of law," Pet. App. A29 n.6, it did not reach the further question of whether the particular characteristics of the 9% surcharge render it a "law * * * which regulates insurance" within the meaning of the insurance savings clause. In our view, a law regulating HMOs *can* constitute a "law * * * which regulates insurance" under some circumstances. Accordingly, if this Court determines that the 9% surcharge "relates to" ERISA plans, it should remand the case to the court of appeals for a determination of whether the particular characteristics of the 9% surcharge applicable to HMOs bring it within the insurance savings clause.

[9] The district court acknowledged that all state hospital rate-setting statutes will "relate to" employee benefit plans—and hence will be subject to ERISA preemption—insofar as "they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." Pet. App. A77-A78.

[assessment] was bound to affect" ERISA plans. *Id.* at 827. Because the ability of States generally to regulate large segments of the health care marketplace may turn on whether the Second Circuit's or the Third Circuit's view of the scope of ERISA preemption is correct, further review by this Court is warranted to resolve the conflict between the two circuits.

Respondents argue (Travelers, etc., Br. in Opp'n 2-3) that this case is likely to have little continuing significance, since the 11% surcharge has already expired and most ERISA plans are currently paying the 13% surcharge because of a congressional enactment giving such plans a tax incentive to do so. See note 5, *supra*. The tax incentive expires, however, on May 12, 1995, see *ibid.*—a date that serves to afford petitioners an opportunity to obtain review in this Court while the 13% surcharge remains in effect. Thus, New York's ability to collect the 13% surcharge after that date—and, consequently, its ability to enforce its all-payor hospital cost-control program—hinges on the result in this case. In addition, the Second Circuit's decision in this case may have a substantial effect on the ability of other States in that Circuit to regulate medical costs. See, *e.g.*, *New England Health Care Employees* v. *Mount Sinai Hosp.*, 846 F. Supp. 190, 195-198 (D. Conn. 1994) (relying on the decision in this case to hold that portions of Connecticut's hospital cost regulatory scheme are preempted under ERISA). Finally, the disposition of the enormous sums of money that have been paid into escrow under the 11% and 9% surcharges remains at issue in this case. See 93-1414 Pet. 6 n.5; 93-1415 Pet. 17 n.16; HANYS Reply Br. 6-7.[10]

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[10] The pendency of health care reform proposals in Congress does not alter our view that certiorari is warranted in this case. If Congress enacts health care reform legislation before the end of this Session—and if such legislation appears to affect the ERISA preemption analysis in this case—

5. The Hospital Association of New York State (HANYS) alone seeks review of the court of appeals' determination that FEHBA preempts the 11% and 13% surcharges. See 93-1415 Pet. 22-25. The court of appeals' ruling with respect to the FEHBA preemption issue is correct and does not conflict with any decision of another court of appeals. Accordingly, further review of that ruling is not warranted.

As the court of appeals explained, petitioner HANYS "do[es] not dispute that the 13% and 11% surcharges satisfy the first two requirements for preemption: the surcharges are a state-imposed 'tax, fee, or other monetary payment,' and they are imposed 'directly or indirectly' on carriers offering FEHBA plans." Pet. App. A14 (quoting 5 U.S.C. 8909(f)(1) (Supp. IV 1992)). The FEHBA preemption dispute in this case thus turns on whether the surcharges are levied "with respect to any payment made from the Fund." 5 U.S.C. 8909(f)(1) (Supp. IV 1992).

Relying on a "straightforward construction" of the statutory language, the court of appeals concluded that the surcharges are imposed "with respect to * * * payment[s] made from the Fund" and hence are preempted by Section 8909(f). Pet. App. A15-A16. In our view, the court correctly rejected HANYS's argument (93-1415 Pet. 23-25) that Section 8909(f) is limited to "premium taxes," at least in any narrow sense of that term. The text of Section 8909(f) makes no reference to premium taxes. And although there are references to premium taxes in the legislative history of Section 8909(f), the court of appeals correctly explained that HANYS's resort to legislative history in this connection is "singularly unenlightening" because "it remains obscure what the various members of Congress *meant* when they referred to 'premium taxes.'" Pet. App. A16.

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the case could of course be remanded to the Second Circuit for reconsideration in light of the newly enacted legislation.

HANYS's attempted reliance on 48 C.F.R. 1631.205-41 (1992), the OPM regulation implementing Section 8909(f), is misconceived for similar reasons. The OPM regulation merely uses the term "premium tax" as a shorthand description of the taxes covered by FEHBA's preemption provision. Contrary to HANYS's position, the regulation stresses the broad preemptive sweep of Section 8909(f), interpreting it to apply to "*all* payments directed by States or municipalities, regardless of how they may be titled, to whom they must be paid, or the purpose for which they are collected," including "*all* forms of direct and indirect measurements on FEHBP premiums, *however modified*" (emphasis added). Nothing in the regulation suggests that Section 8909(f)(1) applies only to the narrow class of premium taxes suggested by HANYS. The court of appeals correctly concluded that there is no conflict between the regulation and OPM's formal opinion letter to New York, and the court properly held that OPM's interpretation of its own regulation is entitled to deference.

Even if the court of appeals' disposition of the FEHBA issue were incorrect, there would be no reason for this Court to review that issue here. As HANYS concedes (93-1415 Pet. 22), the court of appeals' decision on the FEHBA issue does not conflict with the decision of any other court of appeals; no other court of appeals has had occasion to address the issue. Moreover, the FEHBA issue has no relationship to the ERISA preemption issue in this case. Although HANYS now suggests otherwise (HANYS Reply Br. 8), HANYS itself told the court of appeals that, "[w]ith respect to preemption, the two statutes have entirely different provisions. Preemption under ERISA does not equate to preemption under FEHBA." HANYS C.A. Pet. for Reh'g, at 14. The ERISA preemption analysis presents complex and significant legal issues. Granting review of an additional, wholly unrelated issue would serve only to unduly complicate the parties' presentation and the Court's consideration of this case.

CONCLUSION

The petitions for a writ of certiorari in Nos. 93-1408 and 93-1414 should be granted. The petition for a writ of certiorari in No. 93-1415 should be granted, limited to the first question presented.

Respectfully submitted.

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SEPTEMBER 1994

APPENDIX

1. ERISA Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), provides in full:

> Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

2. ERISA Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), provides in relevant part:

> Neither an employee benefit plan described in section 1003(a) of this title, * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts * * *.

(5) (6) (6)

Nos. 93-1408, 93-1414 and 93-1415

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation of Caption See Reverse Side of Cover)

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' SUPPLEMENTAL BRIEF IN OPPOSITION

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13 pp

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

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ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' SUPPLEMENTAL BRIEF IN OPPOSITION

Respondents[1] submit this supplemental brief in response to the brief submitted by the Solicitor General as amicus curiae to express the view of the United States (the "Government") as to whether the petitions for certiorari should be granted in this case.

DISCUSSION

1. *The "relating to" issue.*

With regard to whether the surcharge laws "relate to" ERISA plans, the Government recommends that certiorari be granted because of the importance of the issue and a purported conflict among the circuits. On the first point, the Government asserts that the "Second Circuit's decision erroneously expands ERISA's preemption provisions and, as a consequence, improperly confers an immunity for ERISA plans from generally applicable state laws that have only an indirect economic effect on ERISA plans." (Government's Brief 9.) This assertion seriously distorts the Second Circuit's holding in this case. The court of appeals did not hold that a generally applicable state law is preempted whenever it has an indirect economic effect on ERISA plans. On the contrary, the Second Circuit concluded that the laws at issue here are not laws of general application since they are targeted directly at the users of in-patient hospital care in New York, which (as the Government itself concedes) are overwhelmingly ERISA plans (A-6, 22; Government's Brief 4, 17). The Second Circuit further concluded that the surcharge laws were preempted because they were specifically designed to compel ERISA plans to provide their members with health care through New York's

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[1] This supplemental brief is submitted on behalf of respondents The Travelers Insurance Company, Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Aetna Life Insurance Co., Aetna Health Plans of New York, Inc., Mutual of Omaha Insurance Company, The Union Labor Life Insurance Company and Professional Insurance Agents of New York, Inc. Trust.

financially distressed Blue Cross system, rather than through self-insurance, commercial insurance or an HMO, and, therefore, "purposely interfere[d] with the choices that ERISA plans make for health care coverage." (A-22.) In short, the surcharge laws would have virtually no meaning absent ERISA plans. The Government's characterization of these statutes as "generally applicable" state laws is fundamentally wrong.

Indeed, it is quite surprising that the Government takes issue with the Second Circuit's holding on the "relating to" issue since it strenuously argued in favor of it in an amicus brief submitted below. Specifically, the Government argued before the Second Circuit that the surcharge laws "relate to" ERISA plans for two reasons:

> First, the surcharges "refer to" plans because they single plans out for differential treatment — treatment that is worse than that accorded certain other purchasers of hospital services. For example, a self-funded plan or a plan insured with a commercial insurer must pay the 13% surcharge on hospital rates, while Blue Cross/Blue Shield is exempt. Similarly, plans insured with commercial insurers are also subject to the 11% surcharge, but the Blues are not. Finally, plans that contract with HMOs are liable for the 9% surcharge from which all other individuals and plans are excused.
>
> *Mackey* teaches that statutes cannot single plans out for preferential treatment without running afoul of § 514's "relates to" clause. *Mackey*, 108 S.Ct. at 2190 n.12 ("*[A]ny* state law which singles out ERISA plans, by express reference, for special treatment is preempted." (emphasis by the Court)); *see also Ingersoll-Rand*, 111 S.Ct. at 483 (Texas cause of action "relates to" plan because it "makes specific reference to, and indeed is premised on, the existence of a pension plan."). *A fortiori*, statutes that discriminate against plans as opposed to non-plans "relate to" plans as well.

> Accordingly, the surcharges "refer to" plans within the meaning of ERISA § 514.
>
> In addition, the surcharges have a "connection with" plans, for their intent and effect is to alter plan behavior. The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% surcharges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge. *Shaw*, *Metropolitan [Life Ins. Co.] v. Massachusetts* and *General Electric v. New York Dep't of Labor* all hold that such changes in plan structure and benefit levels constitute the requisite "connection" for purposes of § 514.

(Government's Second Circuit Brief 19-20.)[2] In essence, the Government now argues that the Second Circuit fundamentally misconstrued the law by adopting the Government's position. Yet, the Government has not provided an explanation as to why it has decided to reverse its position, or why this sudden and unexplained reversal necessitates the intervention of this Court.

Further, in its amicus brief in this Court, the Government's analysis of the surcharge statutes is based on a fundamental misunderstanding of those laws. It argues that the surcharge laws do not "relate to" ERISA plans because "the only effect that the surcharges in this case have on ERISA plans is both indirect (because the surcharges do not apply to the plans themselves, but are generally applicable to insurers and other health carriers whose services are purchased both by ERISA plans and others) and solely economic (because the surcharges

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[2] Copies of this brief are being lodged with the Clerk of this Court.

affect only the costs of services ERISA plans purchase, and thus do not dictate the type or nature of benefits that ERISA plans may or must offer to participants or regulate how an ERISA plan must be administered)." (Government's Brief 13) (footnote omitted). The Government is wrong on both points. The 13% surcharge applies directly to self-insured ERISA plans.[3] Therefore, the impact is direct. In addition, the purpose of the surcharge laws is to dictate that ERISA plans provide their members with health care coverage through New York's financially distressed Blue Cross system, rather than through commercial insurance, self-insurance or an HMO. Thus, the laws interfere with an ERISA welfare plan's single most important decision — how best to provide health care to its members.[4] Plainly, the impact of the laws is not solely economic.

The Government's understanding of the facts is also flawed. For instance, the Government repeatedly advances the view that questions involving ERISA's "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), are not presented by this case "since no self-funded ERISA plan is among the plaintiffs." (Government's Brief 14-15 n.7.) The Government also states that "[n]one of the plaintiffs in this case is a self-insured fund, and none of them thus appears to have standing to challenge the application of the 13% surcharge to self-insured funds." (Government's Brief 14 n.5.) Once again, the Government is simply wrong. Questions concerning the "deemer" clause are, indeed, before this Court since the plaintiffs include self-insured plans. For instance, plaintiff The Travelers Insurance Company sued in its capacity as a fiduciary of the Sheridan Catheter plan, a self-funded ERISA plan.

---

[3] New York Public Health Law Section 2807-c(1)(b) requires that the rate for in-patient services be increased by a 13% surcharge when the patient is "enrolled in a self-insured fund."

[4] In the lower courts, the State and the Blues acknowledged that the undisputed purpose of the surcharge laws was to "level the playing field" for the Blues "in their competition with commercial insurers. . . ." (Joint Appendix in the Second Circuit 649.) This buttresses the Second Circuit's conclusion that the purpose of the surcharge laws was to influence ERISA plan behavior.

The Government also argues that certiorari should be granted in this case because there exists a conflict between the decisions of the Second Circuit in this case and the Third Circuit in *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). In their brief in opposition (at 15-17), respondents explained why there is no true conflict. In essence, the New Jersey laws at issue in *United Wire* were fundamentally different from those at issue here. New Jersey's laws were not designed to influence an ERISA welfare plan's most fundamental decision — how best to provide its members with health care. Further, two of the laws at issue in this case — the 9% and 11% surcharges — have nothing to do with hospital reimbursement or the containment of hospital costs. The funds associated with those surcharges end up in New York State's general fund. The Third Circuit had nothing of this kind before it in *United Wire*. Moreover, in *United Wire*, the Third Circuit relied on the Second Circuit's ten-year-old ruling in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), which the Second Circuit overruled in this case. It therefore remains an open question how the Third Circuit would rule on the ERISA preemption issue presented here in light of the Second Circuit's overruling of *Rebaldo*.

2. *The savings clause issue.*

Turning to the savings clause, the Government acknowledges that the Second Circuit applied the correct legal standards to this issue, but argues that the court came to the wrong conclusion. Even if true, those contentions do not warrant this Court's review.

In any event, the Government is mistaken in its analysis of the savings clause issue. The Government erroneously concludes that a regulation of hospital rates intended to influence a "marketplace" in which insurers participate is a regulation of insurance within the meaning of ERISA's savings clause. Although the surcharge laws have an impact on insurance companies, that alone is not enough. As this Court has made clear

in interpreting the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, the exemption at issue is limited to "the business of insurance" and does not apply in the case of any law having an impact on the "business of insurance companies." *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205, 210-11 (1979).

This error infects the Government's analysis of each of the various factors used to identify whether a practice is a regulation of insurance for purposes of ERISA and the McCarran-Ferguson Act. For instance, the Government argues that the surcharges regulate insurance as a matter of common sense because they turn on "the payor's status as a participant in the insurance marketplace," without regard to whether they regulate insurance as such. Likewise, with respect to whether the surcharges regulate a practice that is an integral part of the policy relationship between the insurer and the insured, the Government argues that the surcharges satisfy this requirement since they "are premised on the open enrollment and community rating policies of the Blues and HMOs. . . ." (Government's Brief 15.) As the Second Circuit held in *Howard v. Gleason Corp.*, 901 F.2d 1154, 1159 (2d Cir. 1990), the essence of this factor is whether the statute "dictate[s] any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." The surcharge laws do not directly change any of the terms, conditions or scope of coverage in an insurance contract. They simply regulate hospital rates. Therefore, they do not regulate any practice that is an integral part of the policy relationship between the insurer and the insured.

As to the third McCarran-Ferguson factor, the Second Circuit correctly found that the surcharge laws were not limited to entities in the insurance industry since they involved hospitals, HMOs and New York State itself. The Government's suggestion (at 16) that the third factor has been satisfied "[s]o long as the amount of the surcharges is determined solely by the nature of the payor" is totally beside the point.

3. *The Government has failed to explain why the decision of the Second Circuit warrants review by this Court.*

On the "relating to" issue, the Government's primary concern is that the decision below will undermine the ability of the states to implement legislation controlling hospital costs. This concern is meritless for a number of reasons. First, the court of appeals did not hold or suggest that ERISA precludes a state from regulating hospital rates. By way of example, respondents did not challenge, and the court of appeals did not void, New York's DRG system of hospital rate regulation. On the contrary, respondents challenged, and the court of appeals invalidated, only those aspects of New York's hospital rate system which were specifically designed to alter ERISA plan behavior.

Further, the only case the Government cites to support this concern is *NYSA-ILA Medical and Clinical Servs. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994). That case, however, did not have anything to do with legislation designed to control hospital costs. On the contrary, that case involved a New York State tax on a health care facility operated by an ERISA plan. The sole purpose of the tax was to eliminate New York's budget deficit for the 1990-91 fiscal year.

Moreover, since the court of appeals adopted the position advanced by the Government in its Second Circuit amicus brief on the "relating to" issue, it is difficult to understand why the Government suddenly feels that this result will have pernicious consequences.

With regard to the savings clause issue, the Government does not and cannot argue that this Court's review is needed to resolve a conflict among the circuits or that the Second Circuit's decision is of national significance.

CONCLUSION

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

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Dated: New York, New York
September 27, 1994

(6) (7) (7)

Nos. 93-1408, 93-1414, 93-1415

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

MARIO M. CUOMO, in his official Capacity as Governor of the State of New York, et al.

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' SUPPLEMENTAL BRIEF IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

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Nos. 93-1408, 93-1414, 93-1415

IN THE

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vs.

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

RESPONDENTS' SUPPLEMENTAL BRIEF IN OPPOSITION TO PETITIONS FOR WRIT OF CERTIORARI

Preliminary Statement

This brief is submitted, pursuant to Supreme Court Rule 15.7, on behalf of the respondents the New York State Health Maintenance Organization Conference and twelve health maintenance organizations (collectively referred to as the "HMOs")[1] in response to the *amicus curiae* brief of the United States Solicitor General urging that the petitions for certiorari regarding the three surcharges be granted in this action. Because the HMOs are subject only to the 9% assessment, this brief addresses the preemption of only that assessment.

By urging the Court to grant certiorari on the three surcharges, without analyzing the critical distinctions between them, the Solicitor General has obscured the fact that the 9% assessment relates directly to ERISA plans and is therefore preempted by ERISA. The differences between the 9% and other assessments, which the Solicitor General has attempted to sweep under the rug, undermine not only the merits of the Solicitor General's preemption analysis, but also his discussion of the purported conflict between the Second Circuit's decision in this case and the Third Circuit's decision in *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S.Ct. 382 (1993) ("*United Wire*").

Equally unavailing is the Solicitor General's suggestion that if this Court ultimately affirms the Second Circuit's decision that the 9% assessment "relates to" employee benefit plans, the Court should remand to the Court of Appeals for a determination of whether the assessment falls within the insurance savings clause. Such a suggestion is not only premature, but also is unsupported by the record. Petitioners did not argue below, and do not appear to be arguing here, that the 9% assessment is saved from preemption by the insurance savings clause.

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[1] A list of parent and subsidiary companies, pursuant to Supreme Court Rule 29.1, previously was submitted to the Court in Respondents' Brief in Opposition to Petitions for a Writ of Certiorari, dated April 8, 1994.

Finally, the Solicitor General's statement of the case is factually incorrect with respect to its discussion of the legislative requirements imposed on the Blue Cross/Blue Shield organizations (the "Blues"). Contrary to the Solicitor General's representation, the Blues are not "required" to engage in open enrollment (see *Amicus* Mem. at 3)[2]. While certain Blue Cross/Blue Shield companies might offer insurance to all categories of insureds, only HMOs are statutorily required to open enroll in all markets. Similarly, only HMOs community rate across the board. In this context, the Solicitor General's statement that the Blues are the "'insurer of last resort' for high-risk individuals" (see *Amicus* Mem. at 3), is incomplete, if not misleading. Because HMOs are required to accept all persons requesting coverage, they are at a risk equal to, if not greater than, the Blues.

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[2] References herein to the brief of the Solicitor General shall be designated as "*Amicus* Mem. at __".

ARGUMENT

1. THERE IS NO CIRCUIT CONFLICT AS TO THE 9% ASSESSMENT

The New Jersey statute at issue in *United Wire* involved a surcharge added to the DRG rate to cover bad debt expenses and the cost of uncompensated care provided to the indigent. Regardless of whether a conflict may exist between the Third Circuit and the Second Circuit's decision regarding the 11% and 13% surcharges, there is no conflict regarding the 9% assessment. Unlike the surcharges at issue in *United Wire*, the 9% assessment has nothing whatsoever to do with hospital reimbursement or the bad debt and charity pool.

The 9% assessment imposes a penalty, calculated at 9% of an HMO's aggregate cost of inpatient hospitalization, on HMOs that are unable to enroll a certain target number of Medicaid subscribers. The 9% assessment is not an increase in the DRG rate paid to hospitals, nor do any of the funds raised by the assessment ever reach the hospital providing the services. The funds are directly paid to a State-designated pool administrator and then forwarded to the State's General Fund. In short, the 9% assessment has nothing whatsoever to do with the regulation of hospital care in New York State.

The petitioners and Solicitor General concede that the purpose of the 9% assessment is to bolster the State's Medicaid managed care program by inducing HMOs to shoulder the burden of a larger percentage of the Medicaid population. The fact that the State chose to do this by imposing a penalty calculated as a percentage of the HMOs' hospitalization costs was purely arbitrary. The State could just as easily have chosen a different penalty to achieve the same result.

Thus, contrary to the Solicitor General's allegation, the 9% assessment is not a law of general application designed to vary the cost of hospital services for various payors. (See *Amicus* Mem. at 11). The 9% assessment has nothing to do with hospital rates, is directed solely at HMOs and may be avoided entirely if the HMOs meets their Medicaid targets.

2. THE 9% ASSESSMENT "RELATES TO" ERISA PLANS

Although the Government argued below that the surcharges related to ERISA plans because they disparately applied to such plans and were intended to and did affect plan behavior, it inexplicably reverses its position here and now argues that there is no connection between the 9% assessment and ERISA plans. The Solicitor General's attempt to discount the effect of the 9% assessment by categorizing it now as a "generally applicable state law[] that ha[s] only an indirect economic effect on ERISA plans" (see *Amicus* Mem. at 9) is without merit.

It is difficult to comprehend how a surcharge specifically designed to raise the cost of health care coverage provided by an HMO unless specified Medicaid targets are met is a law of general applicability with *only* an indirect economic impact on ERISA plans. First, the 9% assessment applies only to HMOs; it does not apply to insurance companies or other non-HMO Medicaid providers. Second, the assessment is levied only against those HMOs that fail to meet their Medicaid targets. Those that do meet the targets avoid the assessment entirely. Third, the vast majority of the HMOs' subscribers are beneficiaries of ERISA plans and, as the Second Circuit noted, eighty-eight percent of non-elderly Americans receive some form of private health care coverage through ERISA plans. (A-6)[3]. Thus, the only reason the 9% assessment functions as a meaningful penalty is because of the overwhelming presence of ERISA plans in HMO systems.

The Second Circuit correctly concluded that the 9% assessment forces HMOs either to raise the cost of coverage or to reduce benefits. An HMO that is unable to meet its Medicaid enrollment targets has no choice but to pass the increase on to its subscribers because the only other alternative would be for the HMO to expend reserves — a practice that is not only irresponsible but ultimately unavailing since the surcharge payments would quickly exhaust reserves leaving the HMO bankrupt.

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[3] References herein to the Appendix shall be designated as "A-__".

Thus, the 9% assessment clearly has the requisite connection with ERISA plans.

However, the 9% assessment strikes even more directly at ERISA plans because, in the face of higher costs or reduced benefits, ERISA plans may switch from an HMO not meeting the relevant targets to a different type of coverage. Ironically, in the court below, the Government relied on this very type of market disruption to support its position that the 9% assessment related to ERISA plans. There, the Government asserted that "the surcharges have a connection with plans because their purpose and effect is to alter plan behavior. . . ." Brief for the Secretary of Labor as *Amicus Curiae* at 12, *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1994) (Nos. 93-7132, 7134, 7148).

Contrary to the Solicitor General's suggestion here that the assessment's only impact is "indirect and solely economic" (*Amicus* Mem. at 14), the assessment actually has a direct and disruptive effect on the choices ERISA plans make regarding health care coverage. Because HMOs actually provide care, an ERISA plan cannot select alternative coverage without, in many cases, disrupting the case that is being provided to its employees. This is particularly true if an ERISA plan switches from the comprehensive, coordinated care approach of an HMO to the fragmented approach of fee-for-service indemnity insurance.

The Solicitor General also argues that the requisite connection between the surcharges and ERISA plans is lacking because the surcharges are laws of "general applicability" whose only direct impact is on the HMOs, not the plans themselves. In *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) ("*NYSA-ILA*"), the Second Circuit noted:

> The [state tax] does *not* apply broadly to every sector of society in New York .... Rather, the [tax] targets *only* the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the [tax] was bound to affect them. In a case such as the present one where the plan has chosen to

> provide medical benefits through self-run medical centers, the [tax] operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits.

NYSA-ILA, 27 F.3d at 827 (emphasis added).

The surcharges here are targeted even more narrowly than the tax in *NYSA-ILA*. The 9% assessment does not apply broadly to all sectors of New York society, or even to all sectors of the health care industry or all categories of Medicaid providers. Instead, it is aimed solely at HMO-provided health care benefits.

3. THE ISSUE OF WHETHER THE 9% ASSESSMENT MIGHT FALL WITHIN THE INSURANCE SAVINGS CLAUSE HAS NOT BEEN RAISED BY PETITIONERS AND SHOULD NOT BE ADDRESSED HERE

In analyzing the question of whether the surcharges are preserved by the insurance savings clause, the Second Circuit concluded, as a matter of law, that HMOs do not engage in the business of insurance. Accordingly, the Second Circuit also adopted the conclusion of the district court that the 9% assessment does not fall within the scope of the insurance savings clause. (A-26-27 n.5; A-29 n.6). Recognizing that the 9% assessment was designed solely to induce HMO enrollment in Medicaid managed care programs and to raise money for the State treasury, the petitioners did not assert that the district court erred in its conclusion that the 9% assessment does not fall within the savings clause, nor do they do so here. Indeed, only the Government, both below and before this Court, contends that this is an issue. Here, the Government argues that if this Court ultimately determines that the 9% assessment does relate to ERISA plans, it must remand the issue of whether the assessment falls within the insurance savings clause to the court of appeals. (*Amicus* Mem. at 17 n. 8).

Even if this issue had been raised on appeal, it would have no merit. The record is replete with references to the fact that

the 9% assessment is a device designed to achieve certain Medicaid enrollment objectives and to raise funds for the state treasury. Indeed, the State, which was the sole architect of the law, has never contended differently. The 9% assessment has nothing whatsoever to do with the business of insurance, hospital reimbursement or the bad debt and charity pool. It is designed only to lessen the State's burden under the Medicaid program — a program enforced under New York's Social Services Law, not the Insurance Law. Thus, there is no basis for the Court to remand the issue.

CONCLUSION

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

Dated: Albany, New York
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(1) (8) (8)

Nos. 93-1408, 93-1414, 93-1415

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation of Caption See Reverse Side of Cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED MARCH 9, 1994
CERTIORARI GRANTED OCTOBER 7, 1994

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Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

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CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE TRAVELERS INSURANCE COMPANY,

Plaintiff,

-against-

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, LORNA MCBARNETTE, in her Official Capacity as Acting Commissioner of Health of the State of New York, and SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York,

Defendants.

Case No. 92 Civ. 3999 (LJF)

6/2/92	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $120.00 RECEIPT # 170171 (jl) [Entry date 06/03/92]
6/26/92	5	ANSWER to Complaint by Mario M. Cuomo, Lorna McBarnette, Salvatore R. Curiale (Attorney M. Patricia Smith).; Firm of: Robert Abrams Attorney General State of New York by attorney M. Patricia Smith for defendant Mario M. Cuomo (jr)

8/3/92	14	STIPULATION and ORDER, New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield shall be permitted to intervene as parties deft in this action with full rights of parties, including to participate in oral argument (signed by Judge Louis J. Freeh). (emil)
8/5/92	15	ANSWER to Complaint by Empire Blue Cross, NY State Conference (Attorney Robert A. Bicks, Eileen M. Considine),; by attorney M. Patricia Smith for defendant Mario M. Cuomo (emil) [Entry date 08/07/92]
8/21/92	17	NOTICE OF MOTION by The Travelers Co. for summary judgment, Return date 8/21/92. Rule 3(g) Statement & Affidavits in support are attached (emil)
8/21/92	18	MEMORANDUM by The Travelers Co. in support of [17-1] motion for summary judgment (emil)
8/31/92	19	STIPULATION and ORDER, that the Hospital Association of New York State be permitted to intervene as a party deft in this action subject to the following limitation: Until pltff's motion for summary judgment is disposed of, Intervenor will not initiate discovery other than discovery directly related to discovery initiated by any other party. Intervenor agrees to comply with the schedule for motions and cross-motion for summary judgment which was agreed to by the parties on 7/14/92 (signed by Judge Louis J. Freeh). (emil) [Entry date 09/01/92]

9/28/92	21	ANSWER to Complaint by Hospital Association; Firm of: Sherrin & Glasel (emil)
10/2/92	23	NOTICE OF CROSS MOTION by Hospital Association for summary judgment, Return date 10/26/92. Rule 3(g) statement in support is attached (emil)
10/2/92	24	MEMORANDUM by Hospital Association in opposition to [17-1] motion for summary judgment and in support of cross-motion for summary judgment (emil)
10/2/92	25	AFFIDAVIT in support of Daniel Sisto Re: [23-1] cross motion for summary judgment (emil)
10/2/92	26	NOTICE OF CROSS MOTION by Empire Blue Cross, NY State Conference for summary judgment, Return date 10/26/92. Rule 3(g) Statement in support is attached (emil)
10/2/92	27	AFFIDAVIT in support of Arthur B. Klein Re: [26-1] cross motion for summary judgment (emil)
10/2/92	28	MEMORANDUM by New York State Conf, Empire Blue Cross in opposition to pltff's motion for a preliminary injunction (emil)
10/2/92	29	MEMORANDUM by Empire Blue Cross, NY State Conference in opposition to [17-1] motion for summary judgment (emil)
10/2/92	30	AFFIDAVIT in support of Jerry Weissman Re: [26-1] cross motion for summary judgment (emil)

10/2/92	31	AFFIDAVIT in support of Albert F. Antonini Re: [26-1] cross motion for summary judgment (emil)
10/5/92	32	NOTICE OF MOTION & CROSS MOTION by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin for summary judgment, Return date 10/26/92. Rule 3(g) Statement and Affidavits in support are attached (emil)
10/5/92	33	MEMORANDUM by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin in opposition to [17-1] motion for summary judgment and in support of defts' motion and cross-motions for summary judgment (emil)
10/5/92	34	RESPONSE by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin Re: pltffs' 3(g) Statement (emil)
10/5/92	35	RESPONSE by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin Re: pltff's 3(g) statement (emil)
10/19/92	37	STIPULATION and ORDER, that the NY State Health Maintenance Organization Conference, Health Services Medical Corporation, MVP Health Plan Wellcare, Mid-Hudson, Oxford Health Plan, Capital District Physicians Health Plan, ChoiceCare Long Island, Independent Health, Travelers of New York, Physicians Health Services, Preferred Care, and U.S. Healthcare (collectively referred to as "the HMO's") may intervene in said actions subject to the conditions listed in this Stip & Order (signed by Judge Louis J. Freeh). (emil) [Entry date 10/20/92]

10/21/92	38	REPLY MEMORANDUM by The Travelers Co. re: in support of [17-1] motion for summary judgment and in opposition to defendant's and intervenor's cross-motions for summary judgment. (emil) [Entry date 10/22/92]
10/21/92	39	RESPONSE by The Travelers Co. Re: Defendant's and Intervenor's statements pursuant to Rule 3(g) statement. (emil) [Entry date 10/22/92]
10/28/92	40	SUR-REPLY by Hospital Association Re: in opposition [17-1] motion for summary judgment and in support of its cross-motion for summary judgment (emil)
10/28/92	41	AFFIDAVIT in support of Darrell E. Jeffers Re: [23-1] cross motion for summary judgment (emil)
10/29/92	42	REPLY MEMORANDUM by Empire Blue Cross, NY State Conference re: [26-1] cross motion for summary judgment, [23-1] cross motion for summary judgment (emil)
10/29/92	44	RESPONSE by Empire Blue Cross, NY State Conference Re: pltffs' Health Ins. Association of America purs. to Southern Dist. Rule 3(g), dated October 21, 1992. (emil)
10/29/92	45	AFFIDAVIT of Jerry Weissman Re: in reply to the affidavits of Paul V. Bruno and Terence D. Tuohy (emil)

10/29/92	46	AFFIDAVIT of Alan Rachlin by Mario M. Cuomo, Salvatore R. Curiale (emil) [Entry date 10/30/92]
10/29/92	47	REPLY MEMORANDUM by Mario M. Cuomo, Salvatore R. Curiale re: motion & cross motions for summary judgment and in opposition to pltff's motions for summary judgment (emil) [Entry date 10/30/92]
11/6/92	52	AFFIDAVIT in support of Robert A. Sujecki Re: [17-1] motion for summary judgment (emil)
11/10/92	53	ORDER, consolidating this case with 92 cv 5419 for all pretrial and trial purposes (signed by Judge Louis J. Freeh); copies mailed (emil) [Entry date 11/12/92]
11/12/92	54	ORDER, Aetna Life Ins. Co. and Aetna Health Plans of NY, Inc.'s motion for a preliminary injunction is granted. Travelers and HIAA have also moved for summary judgment. All of these dispositive motions will be addressed in a separate opinion (signed by Judge Louis J. Freeh); Copies mailed (emil) [Entry date 11/13/92]
11/17/92	56	MEMORANDUM by New York State Conf, Empire Blue Cross re: [50-1] opposition memorandum (emil)
11/18/92	58	STIPULATION and ORDER, withdrawing Count II and III of the complaint (signed by Judge Louis J. Freeh). (emil) [Entry date 11/19/92]

12/2/92	62	Intervenor's COMPLAINT by NYSHMOC against Hospital Association, Empire Blue Cross, NY State Conference (emil) [Entry date 12/04/92]
12/21/92	66	ANSWER by Salvatore R. Curiale, Mark Chassin, Mary Jo Bane and Robert Abrams to [62-1] intervenor complaint by attorney (emil)
12/31/92	67	ANSWER by New York State Conf, Empire Blue Cross to [62-1] intervenor complaint Firm of: Hinman, Straub, Pigors etc. by attorney (emil)
1/11/93	68	MEMORANDUM by NYSHMOC in support of the motion for summary judgment of pltffs' Health Insurance Association of America, *et al* and in reply to deft's motion for summary judgment (emil)
2/3/93	69	MEMORANDUM OPINION #71013 granting in part, denying in part [17-1] motion for summary judgment, denying [26-1] cross motion for summary judgment, denying [23-1] cross motion for summary judgment, denying [32-1] motion for summary judgment. Because the Court finds that the three Surcharges are all preempted by ERISA, defts are enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection with their coverage of any ERISA plans. Because the Court also finds that both the 11% and 13% Surcharges are preempted by FEHBA, defts are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program. Finally, because the

		Court finds that Items 1,2,3 and 5 of the Actuarial Letter are also preempted under ERISA, defts are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans (signed by Judge Louis J. Freeh); Copies mailed. (emil) [Entry date 02/05/93]
2/8/93	70	NOTICE OF MOTION by New York State Conf, Empire Blue Cross to stay this Court's Opinion and Order dated 2/3/93 pending appeal, Return date 2/9/93 (emil)
2/8/93	71	MEMORANDUM by New York State Conf, Empire Blue Cross in support of [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)
2/8/93	72	AFFIDAVIT in support of Bartley J. Costello by Empire Blue Cross Re: [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)
2/8/93	73	AFFIDAVIT in support of Jerry Weissman by Empire Blue Cross Re: [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)
2/9/93	74	MEMORANDUM by The Travelers Co. in opposition to [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/9/93	75	AFFIDAVIT in opposition of Timothy F. Lyons by The Travelers Co. Re: [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)
2/9/93	76	MEMORANDUM OPINION #71044 granting in part, denying in part [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal. The Order will be stayed as to the 13% Surcharge, but not as to the 9% or 11% Surcharges. However, pltffs and any other parties subject to the 9% or 11% Surcharges shall pay those funds into an interest-bearing escrow account pending resolution of defts' appeal (Signed by Judge Louis J. Freeh); Copies mailed. (emil) [Entry date 02/10/93]
2/9/93	77	NOTICE OF APPEAL by Hospital Association; from [69-1] order. Copies of notice of appeal mailed to Attorney(s) of Record: Hinman, Straum, Pigors & Manning; Breed, Abbott & Morgan; Hogan & Hartson; Cough, White, Brenner, Howard & Feigenbaum; Office of the Attorney General; U.S. Atty's Office; Paul, Weiss, Rifkind, Wharton & Garrison; Windels, Marx, Davies & Ives. Appeal record due on 3/11/93 (emil) [Entry date 02/16/93]

2/16/93	78	NOTICE OF APPEAL by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin; from [69-1] order. Copies of notice of appeal mailed to Attorney(s) of Record: Craig P. Murphy; U.S. Atty, SDNY; Sherrin & Glasel; Hinman, Straub, Pigors & Manning; Breed, Abbott & Morgan. Appeal record due on 3/18/93 (emil) [Edit date 02/16/93]
2/19/93	79	NOTICE OF MOTION by Mario M. Cuomo, Salvatore R. Curiale to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit, Return date 2/3/93. Affidavits in support attached. (emil)
2/19/93	80	MEMORANDUM by Mario M. Cuomo, Salvatore R. Curiale in support of [79-1] motion to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit (emil)
2/22/93	81	AFFIDAVIT in opposition of Kathryn Allen by NYSHMOC Re: [79-1] motion to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit, [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)
2/22/93	82	MEMORANDUM by NYSHMOC in opposition to [79-1] motion to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit, [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/23/93	83	NOTICE OF APPEAL by New York State Conf, Empire Blue Cross; from [69-1] order. Copies of notice of appeal mailed to Attorney(s) of Record: Couch, White; Hogan & Hartson; Sherrin & Glasel; Carole Jeandheur; Windel, Marx; Robert Abrams; Lorraine Novinski; Paul, Weiss. (jf) [Entry date 02/24/93]
2/24/93	—	Notice of appeal and certified copy of docket to USCA: [83-1] appeal by Empire Blue Cross, New York State Conf; Copy of notice of appeal sent to District Judge. (jf)
3/5/93	84	NOTICE OF CROSS-APPEAL by The Travelers Co. from order dtd: 2/5/93. Copies sent to: Atty. Gen NYS; Robert Bicks; Philip Rosenberg; Bartley Costello; Harold Iselin; Clifford Stromberg. (jf) [Entry date 03/08/93]
3/10/93	85	Notice that the original record on appeal has been certified and transmitted to the U.S. Court of Appeals (emil) [Entry date 03/12/93]
4/28/93	86	ORDER, Pending a determination by the U.S.C.A., 2nd Circuit of the appeals from this Court's 2/3/93 order, the named parties to this action, including Travelers, in its capacity as claims fiduciary of the Railroad Plans, are directed to pay the 13% differential with respect to all hospital claims, where applicable

under Sec. 2807-c(1)(b) of the NY Public Health Law, whether incurred before or after the date hereof. This order applies to pltffs Health Ins. Association of America, American Council of Life Ins., and Life Ins. Council of NY, Inc. only to the extent they serve directly as fiduciaries of ERISA plans. This order does not impose on any person any obligation to pay the 13% differential except to the extent such obligation otherwise exists under the relevant contracts and/or NY law (signed by Judge Louis J. Freeh); Copies mailed (emil) [Entry date 05/06/93]

9/3/93 87 JUDGMENT that defts' cross-motions are denied. Pltffs' motions for summary judgment are granted in part and denied in part. Defts are enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection w/their coverage of any ERISA plans because the Court finds that the three Surcharges are all preempted by ERISA. Defts are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program because the Court finds that both the 11% and 13% Surcharges are preempted by FEHBA. Defts are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans because the Court finds that Items 1, 2, 3 and 5 of the Actuarial Letter are also preempted under ERISA (signed by Judge Louis J. Freeh); Mailed copies and notice of right to appeal. (emil) [Entry date 09/09/93]

10/19/93	88	ORDER, to amend this Court's Opinion & Order of 2/9/93 to provide that: (1) pltffs may, at their option, pay some or all of the funds relating to the 11% supplementary payment rate conversion factor etc. instead of retaining them in an escrow account; and (2) pltff Aetna Health Plans of New York, Inc. and plaintiff-intervenor The Travelers Health Network, Inc. may pay, at their option, some or all of their funds relating to the 9% increase factor etc. instead of retaining them in an escrow account etc., that the judgment clerk amend the judgment entered on 9/9/93 in accordance with the foregoing (as indicated). (signed by Judge Morris E. Lasker); Copies mailed (sc) [Entry date 10/21/93]
11/3/93	89	JUDGMENT that defts' cross-motions are denied. Pltffs' motions for summary judgment are granted in part and denied in part. Defts are enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection w/ their coverage of any ERISA plans because the Court finds that the three Surcharges are all preempted by ERISA. Defts are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program because the Court finds that both the 11% and 13% Surcharges are preempted by FEHBA. Defts are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans because the Court finds that Items 1, 2, 3 and 5 of the Actuarial Letter are also preempted under

ERISA. The Court's Opinion and Order of 2/9/93 is amended to provide that: 1) pltffs may, at their option, pay some or all of the funds relating to the 11% supplementary payment rate conversion factor purs. to the terms of NY's Omnibus Revenue Act of 1992, instead of retaining them in an escrow account and 2) pltff Aetna Health Plans of NY, Inc. and pltff-intervenor The Travelers Health Network, Inc. may pay, at their option, some or all of the funds relating to the 9% increase factor purs. to the terms of NY's Omnibus Revenue Act of 1992 instead of retaining them in an escrow account, and the Court's Order of 10/19/93 does not create an obligation on the part of self-insured plans to pay the 11% surcharge, and all payments made purs. to NY's Omnibus Revenue Act of 1992 may be under protest (Parkison, J., Clerk); Mailed copies and notice of right to appeal. (emil) [Entry date 11/04/93]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY AND PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs,

-against-

MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, MARY JO BANE, in her Official Capacity as Commissioner of Social Services of the State of New York, SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York, and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York,

Defendants.

Case No. 92 Civ. 5419 (LJF)

7/20/92	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $ 120.00 RECEIPT # 173340 (jl) [Entry date 07/22/92]
7/31/92	5	Notice of asgmnt to Judge Louis J. Freeh Copy of notice and judge's rules mailed to Attorney(s) of record: Sidney S. Rosdeitcher, Clifford D. Stromberg. (1a)
8/10/92	9	AMENDED COMPLAINT by The Health Insurance, The Amer. Council, Life Insurance, Aetna Life Insurance, Aetna Health, Mutual of Omaha, Union Labor Life, Professional Ins., (Answer due 8/24/92 for Robert Abrams, for Salvatore R. Curiale, for Mary Jo Bane, for Mark Chassin) amending [1-1] complaint; Summons issued. (emil) [Entry date 08/18/92]
8/11/92	6	ANSWER to Complaint by Mark Chassin, Mary Jo Bane, Salvatore R. Curiale, Robert Abrams (Attorney Jane Lauer Barker), (emil)
8/14/92	8	ANSWER by Mark Chassin, Mary Jo Bane, Salvatore R. Curiale, Robert Abrams (Attorney) to amended complaint (emil) [Entry date 08/18/92]
8/19/92	12	STIPULATION and ORDER, New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield be permitted to intervene as parties deft in this action (signed by Judge Louis J. Freeh). (emil) [Entry date 08/20/92]

8/21/92	14	NOTICE OF MOTION by The Health Insurance, The Amer. Council, Life Insurance, Aetna Life Insurance, Aetna Health, Mutual of Omaha, Union Labor Life, Professional Ins. for summary judgment, Return date 10/26/92. Rule 3(g) Statement and Affidavits in support are attached (emil) [Entry date 09/01/92]
8/21/92	16	NOTICE OF MOTION by Aetna Life Insurance, Aetna Health, Mutual of Omaha for preliminary injunction, Return date 10/26/92 (emil) [Entry date 09/01/92]
8/24/92	13	NOTICE OF MOTION by Aetna Life Insurance, Aetna Health for preliminary injunction, Return date 10/26/92 (emil)
8/31/92	15	MEMORANDUM by The Health Insurance, The Amer. Council, Life Insurance, Aetna Life Insurance, Aetna Health, Mutual of Omaha, Union Labor Life, Professional Ins. in support of [14-1] motion for summary judgment (emil) [Entry date 09/01/92]
8/31/92	17	MEMORANDUM by Aetna Life Insurance, Aetna Health, Mutual of Omaha in support of [16-1] motion for preliminary injunction (emil) [Entry date 09/01/92]
9/8/92	18	ANSWER by New York State Conf, Empire Blue Cross an (Attorney B.J. Costello, James J. Sabella) to amended complaint; by attorney Jane Lauer Barker for defendant Robert Abrams (emil)

10/2/92	22	NOTICE OF CROSS MOTION by New York State Conf, Empire Blue Cross an for summary judgment, Return date 10/26/92. Rule 3(g) statement in support is attached (emil)
10/2/92	23	AFFIDAVIT in support of Arthur B. Klein Re: [22-1] cross motion for summary judgment (emil)
10/2/92	24	MEMORANDUM by New York State Conf, Empire Blue Cross an in opposition to [14-1] motion for summary judgment and in support of Intervenors' Cross-Motions for summary judgment (emil)
10/2/92	25	MEMORANDUM by New York State Conf, Empire Blue Cross an in opposition to pltffs' motion for a preliminary injunction (emil)
10/2/92	26	AFFIDAVIT in support of Jerry Weissman Re: [22-1] cross motion for summary judgment (emil)
10/2/92	27	AFFIDAVIT in support of Albert F. Antonini Re: [22-1] cross motion for summary judgment (emil)
10/15/92	28	STIPULATION and ORDER, that the Hospital Association of NY State be permitted to intervene as parties deft in this action with full rights of parties, including without limitation rights of appeal, to participate in oral argument and at trial, as well as to submit affidavits where appropriate, subject to the limitations listed in this stip and order (signed by Judge Louis J. Freeh). (emil)

10/16/92	29	Filed Memo-Endorsement on letter dated 10/8/92, NYSHMOC may intervene subject to the conditions stated herein (signed by Judge Louis J. Freeh) (emil) [Entry date 10/19/92]
10/19/92	30	MEMORANDUM by Mark Chassin, Mary Jo Bane, Salvatore R. Curiale, Robert Abrams in opposition to [13-1] motion for preliminary injunction, [16-1] motion for preliminary injunction (emil)
10/20/92	31	AFFIDAVIT in support of Kathryn Allen by The Health Insurance Re: [14-1] motion for summary judgment (emil)
10/20/92	32	MEMORANDUM by NYSHMOC in support of the motion for summary judgment of pltffs' Health Ins. Association of America and in reply to deft's motion for summary judgment (emil) [Entry date 12/28/92]
10/21/92	33	REPLY MEMORANDUM by Aetna Life Insurance, Aetna Health re: in support [14-1] motion for summary judgment and in opposition to cross-motions of defendants and intervenors. (emil) [Entry date 10/22/92]
10/26/92	34	REPLY by Aetna Life Insurance, Aetna Health, Mutual of Omaha Re: [13-1] motion for preliminary injunction (emil)
10/29/92	35	REPLY MEMORANDUM by New York State Confe, Empire Blue Cross an re: [22-1] cross motion for summary judgment (emil)

10/29/92	37	AFFIDAVIT of Jerry Weissman Re: in reply to the affidavits of Paul V. Bruno and Terence D. Tuohy (emil)
10/29/92	38	RESPONSE by New York State Conf, Empire Blue Cross an Re: pltffs' Health Ins. Association of America, statement purs. to Southern Dist, dated 10/21/92 (emil)
11/10/92	—	ORDER, consolidating this case with 92 cv 3999 (lead case) for all pretrial and trial purposes (signed by Judge Louis J. Freeh). For original entry see 92 cv 3999, doc. #53; Copies mailed (emil) [Entry date 11/12/92] [Edit date 11/12/92]
11/10/92	—	Consolidated Member Case. Lead Case Number: 1CV92 3999 (emil) [Entry date 11/12/92]

[For further docket entries see entries for 92 Civ. 3999 (LJF).]

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

93-7132L, 93-7134CON, 93-7148CON and 93-7194XAP

TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiff-Appellees,

NYS HEALTH MAINTENANCE ORGANIZATION CONFERENCE,

Plaintiff-Intervenor-Appellee,

against

MARIO CUOMO, in his Official Capacity as governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

2/17/93 Copy of district court docket entries and notice of appeal on behalf of Appellant Hospital Association filed. [93-7132] Form C due on 2/19/93. Form D due on 2/19/93. (com) [93-7132]

2/17/93 Copy of district court docket entries and notice of appeal on behalf of Appellant Mario Cuomo in 93-7134, Appellant Mark Chassin in 93-7134, Appellant Salvatore R. Curiale in 93-7134, Appellant Mary Jo Bane in 93-7134, Appellant Robert Abrams in 93-7134 filed. [93-7134] Form C due on 2/26/93. Form D due on 2/26/93. (com) [93-7134]

2/24/93 Copy of district court docket entries and notice of appeal on behalf of Appellants New York State Conf, Empire Blue Cross in 93-7148 filed. [93-7148] Forms C and D due on 3/5/93. (cop) [93-7148]

3/8/93 Copy of district court docket entries and notice of appeal on behalf of Appellee-Cross-Appellant Travelers Insurance in 93-7194 filed. [93-7194] Form C due on 3/15/93. Form D due on 3/15/93. (com) [93-7194]

3/17/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7148 brief RECEIVED. Problem: wrong color brief. (onl) [93-7132]

3/17/93 Joint appendix received. Number of volumes: 3. Problem: awaiting correction of brief. (onl) [93-7132]

3/18/93 Appellant-Cross-Appellee Hospital Association in 93-7132 brief FILED with proof of service. (disclosure statement attached to brief) (onl) [93-7132]

3/18/93 Appellants-Cross-Appellees Mario Cuomo, Mark Chassin, Salvatore R. Curiale, Mary Jo Bane, and Robert Abrams in 93-7134 brief FILED with proof of service. (onl) [93-7132]

3/19/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7148 brief FILED with proof of service. (disclosure statement attached to brief) (onl) [93-7132]

3/19/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7148 joint appendix filed w/pfs. Number of volumes: 3. (onl) [93-7132]

3/19/93 New party added: Secretary of Labor as *amicus curiae* on appeal. (unv) [93-7132]

3/19/93 *Amicus Curiae* Secretary of Labor in 93-7132 brief filed with proof of service. (unv) [93-7132]

3/30/93 *Amicus Curiae* State of Connecticut in 93-7132 brief filed with proof of service. (unx) [93-7132]

4/14/93 Appellees NYS Health Maint, MVP Health Plan, WellCare of New York, Mid-Hudson Health, Oxford Health Plan, Capital District, ChoiceCare LI, Independent Health, Travelers of NY, Physicians Health, Preferred Care, and U.S. Healthcare in 93-7132 brief filed with proof of service. (onl) [93-7132]

4/14/93 Appellee-Cross-Appellant Travelers Insurance, and Appellees Health Insurance, American Council, Life Ins. Council, Aetna Life Ins., Aetna Health Plans, Mutual of Omaha Ins., Union Labor Life Ins, and Professional Ins in 93-7132 oversized brief filed with proof of service. (onl) [93-7132]

4/16/93 *Amicus Curiae* USA in 93-7132 brief filed with proof of service. (unv) [93-7132]

4/28/93 Appellant-Cross-Appellee Hospital Association in 93-7132 reply brief filed with proof of service. Satisfy appellant's reply brief due. (onl) [93-7132]

4/28/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7132 reply brief filed with proof of service. Satisfy appellant's reply brief due. (onl) [93-7132]

4/29/93 Appellants-Cross-Appellees Mario Cuomo, Mark Chassin, Salvatore R. Curiale, Mary Jo Bane, and Robert Abrams in 93-7132 reply brief filed with proof of service. Satisfy appellant's reply brief due. (onl) [93-7132]

5/17/93 Order FILED GRANTING motion to participate as *amicus* [383487-1] by Movant Natl Carriers' Conf, endorsed on motion form dated 4/14/93., GRANTING motion to file brief as *amicus curiae* [383487-2] by *Amicus Curiae* Natl Carriers' Conf, endorsed on motion form dated 4/14/93. (cal) [93-7132]

5/17/93 *Amicus Curiae* Natl Carriers' Conf in 93-7132 brief filed with proof of service. (cal) [93-7132]

5/17/93 Order FILED GRANTING motion to file brief as *amicus curiae* [383520-2] by Movant Electrical Industry, GRANTING motion to participate as *amicus* [383526-1] by Movant Electrical Industry, U.F.C.W. Funds, GRANTING motion to file brief as *amicus curiae* [383526-2] by *Amicus Curiae* Electrical Industry, U.F.C.W. Funds, endorsed on motion form dated 4/14/93. (cal) [93-7132]

5/17/93 *Amicus Curiae* Electrical Industry and U.F.C.W. Funds brief filed with proof of service. (cal) [93-7132]

5/20/93 Case heard before LUMBARD, CARDAMONE, MCLAUGHLIN, C.JJ (TAPE: 216+217) (car) [93-7132]

10/25/93 Judgment of the District Court, SDNY, is AFFIRMED in part and REVERSED in part by signed opinion FILED (JMCL). (onw) [93-7132]

10/25/93 Judgment filed. (onw) [93-7132]

11/8/93 Appellant-Cross-Appellee Hospital Association in 93-7132 Petition for rehearing, with suggestion for rehearing *en banc* [457705-2] with proof of service filed. (onw) [93-7132]

11/8/93 Appellant-Cross-Appellees Salvatore R. Curiale in 93-7134, Mark Chassin in 93-7134, and Mario Cuomo in 93-7134 Petition for rehearing [457921-1] with proof of service filed. (onw) [93-7132]

11/8/93 Appellant-Cross-Appellees Empire Blue Cross in 93-7148, and New York State Conference in 93-7148 Petition for rehearing, and petition for rehearing *en banc* [457978-2] with proof of service filed. (onw) [93-7132]

1/12/94 Order FILED GRANTING petition for REHEARING [457705-1] by Appellant-Cross-Appellee Hospital Association [457921-1] and by Appellant-Cross-Appellees Salvatore R. Curiale, Mark Chassin, Mario Cuomo, [457978-1] and by Appellant-Cross-Appellees Empire Blue Cross, New York State Conference. No additional briefing or oral argument is required. The panel will file an amended opinion forthwith. (onw) [93-7132]

1/14/94 Amended published signed opinion filed. (JMCL). (onw) [93-7132]

1/19/94 Appellant-Cross-Appellee Hospital Association motion for stay mandate pending application for a writ of certiorari FILED (w/pfs). [477805-1] (ono) [93-7132]

1/19/94 Appellant-Cross-Appellee Empire Blue Cross motion for stay of mandate and judgment pending application for a writ of certiorari. If stay is denied—a 3 business day extension of time before issuance of the mandate, to afford the parties an opportunity to request a stay from the Supreme Court FILED (w/pfs). [477813-1] (ono) [93-7132]

1/20/94 Appellant-Cross-Appellee Mario Cuomo motion for stay of mandate pending application for a writ of certiorari FILED (w/pfs). [477820-1] (ono) [93-7132]

1/20/94 Appellant-Cross-Appellee Mario Cuomo memorandum of law in support of motion for stay pending application to the Supreme Court for a writ of certiorari # [477820-1] by Appellant-Cross-Appellee Mario Cuomo filed. (ono) [93-7132]

2/7/94 Order FILED GRANTING motion for stay of mandate and judgment pending application for a writ of certiorari [477813-1] by Appellant-Cross-Appellee Empire Blue Cross, endorsed on motion form dated 1/19/94. (JEL, RJC, JMcL, CJJ) (ono) [93-7132]

2/7/94 Order FILED GRANTING motion for stay of mandate pending application for a writ of certiorari [477805-1] by Appellant-Cross-Appellee Hospital Association, of New York State endorsed on motion form dated 1/19/94. (JEl/RJC/JMcL, CJJ) (ono) [93-7132]

2/7/94 Order FILED GRANTING motion for stay of mandate pending application for a writ of certiorari [477820-1] by Appellant-Cross-Appellee Mario Cuomo, and all other state defendants endorsed on motion form dated 1/20/94. (ono) [93-7132]

3/7/94 Order FILED DENYING petitions for rehearing *en banc* [457705-2] by Appellants-Cross-Appellees NYS Conference of Blue Cross & Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York [457978-2]. (onw) [93-7132]

3/17/94 Notice of filing petition for writ of certiorari for Appellant-Cross-Appellee Mario Cuomo in 93-7132 dated 3.9.94 filed. Supreme Ct#: 93-1414. (ona) [93-7132]

3/17/94 Notice of filing petition for writ of certiorari for Appellant-Cross-Appellee New York State Conf in 93-7132 dated 3.9.94 filed. Supreme Ct#: 93-1408. (ona) [93-7132]

3/17/94 Notice of filing petition for writ of certiorari for Appellant-Cross-Appellee Hospital Association in 93-7132 dated 3.9.94 filed. Supreme Ct#: 93-1415. (ona) [93-7132]

IN THE SUPREME COURT OF THE UNITED STATES

Order Granting Writ of Certiorari, dated October 7, 1994

FRIDAY, OCTOBER 7, 1994

CERTIORARI GRANTED

93-1408) NY STATE CONF. OF BLUE CROSS V. TRAVELERS INSURANCE, ET AL.
)
93-1414) CUOMO, GOVERNOR OF NY, ET AL V. TRAVELERS INSURANCE, ET AL.
)
93-1415) HOSP. ASSOC. OF NY STATE V. TRAVELERS INSURANCE, ET AL.

The petitions for writs of certiorari in Nos. 93-1408 and 93-1414 are granted. The petition for a writ of certiorari in No. 93-1415 is granted limited to Question 1 presented by the petition. The briefs of petitioners are to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Wednesday, November 16, 1994. The briefs of respondents are to be filed with the Clerk and served upon opposing counsel counsel on or before 3 p.m., Tuesday, December 13, 1994. Reply briefs, if any, are to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Thursday, December 29, 1994. Rule 29.2 does not apply. The cases are consolidated and a total of one hour is allotted for oral argument.

IN THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Amended Opinion of United States Court of Appeals for the Second Circuit, dated January 14, 1994

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Nos. 1514, 1515, 1516, 1667 August Term, 1992

(Argued: May 20, 1993 Decided: October 25, 1993)

Opinion Amended: Jan. 14, 1994

Docket Nos. 93-7132L, 93-7134CON, 93-7148CON, 93-7194XAP

THE TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs-Appellees,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Plaintiffs-Intervenors-Appellees,

v.

MARIO M. CUOMO, in his official capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

Before: LUMBARD, CARDAMONE, and McLAUGHLIN, *Circuit Judges.*

Appeal and cross-appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. The district court held, *inter alia*, that: (1) certain provisions of New York Public Health Law § 2807-c are preempted by ERISA, 29 U.S.C. §§ 1001-1461, and FEHBA, 5 U.S.C. §§ 8901-8914; and (2) ERISA also preempts parts of Actuarial Letter No. 5, issued by New York's Department of Insurance.

Affirmed in part; reversed in part.

M. PATRICIA SMITH, Ass't Attorney General, New York, NY (Robert Abrams, Attorney General of the State of New York, Jane Lauer Barker, Ass't Attorney General in Charge of Labor Bureau, New York, NY, of counsel), *for Defendants-Appellants-Cross-Appellees.*

ROBERT A. BICKS, New York, NY (James J. Sabella, Patricia Anne Kuhn, Breed Abbott & Morgan, New York, NY; Bartley J. Costello III, Eileen M. Considine, David J. Oakley, Hinman, Straub, Pigors & Manning, P.C., Albany, NY, of counsel), *for Intervenors-Defendants-Appellants-Cross-Appellees Empire Blue Cross & Blue Shield and The New York State Conference of Blue Cross & Blue Shield Plans.*

JEFFREY J. SHERRIN, Albany, NY (Philip Rosenberg, Sherrin & Glasel, Albany, NY, of counsel), *for Intervenor-Defendant-Appellant-Cross-Appellee Hospital Association of New York State.*

CRAIG P. MURPHY, New York, NY (Darrell M. Joseph, David B. Kostman, Windels, Marx, Davies & Ives, New York, NY; Clifford D. Stromberg, David Hensler, A. Lee Bentley, III, Hogan & Hartson, Washington, DC; David M. Ermer, Brad W. Spencer, Gordon & Barnett, Washington, DC, of counsel), *for Plaintiff-Appellee-Cross-Appellant The Travelers Insurance Company, and Plaintiffs-Appellees Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Mutual of Omaha Insurance Company, The Union Labor Life Insurance Company, Aetna Life Insurance Company and Aetna Health Plans of New York, Inc. and Professional Insurance Agents of New York, Inc. Trust.*

HAROLD N. ISELIN, Albany, NY (Barbara S. Brenner, Steve T. Engelman, Couch, White, Brenner, Howard & Feigenbaum, Albany, NY, of counsel), *for Plaintiffs-Intervenors-Appellees New York State Health Maintenance Organization Conference, Capital District Physicians' Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., Mohawk Valley Physicians' Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc., and Wellcare of New York, Inc.*

Stuart E. Schiffer, Acting Ass't Attorney General, Washington, DC (Roger S. Hayes, U.S. Attorney, Anthony J. Steinmeyer, Scott R. McIntosh, Appellate Staff, Civil Division, Dep't of Justice, Washington, DC, of counsel), *filed a brief on behalf of the United States as Amicus Curiae.*

Susan M. Green, Trial Attorney, U.S. Dep't of Labor, Washington, DC (Judith E. Kramer, Deputy Solicitor of Labor, Marc I. Machiz, Associate Solicitor, Plan Benefits Security Division, Karen L. Handorf, Counsel for Decentralized and Special Litigation, Eric G. Serron, Trial Attorney, U.S. Dep't of Labor, Washington, DC, of counsel), *filed a brief on behalf of the Secretary of Labor as Amicus Curiae.*

Hugh Barber, Ass't Attorney General, Hartford, CT (Richard Blumenthal, Attorney General of the State of Connecticut, Richard J. Lynch, Arnold I. Menchel, Paul J. Lahey, Phyllis E. Hyman, Ass't Attorneys General, Hartford, CT, of counsel), *filed a brief on behalf of the State of Connecticut as Amicus Curiae.*

Benjamin W. Boley, Washington, DC, (William H. Dempsey, Shea & Gardner, Washington, DC, of counsel), *filed a brief on behalf of the National Carriers' Conference Committee as Amicus Curiae.*

Edward J. Groarke, Garden City, NY (Colleran, O'Hara & Mills, of counsel), *filed a brief on behalf of Trustees of and The Pension, Hospitalization Benefit Plan of the Electrical Industry and Trustees of and United Food and Commercial Workers Local 174 Health Care Fund, Trustees of and United Food and Commercial Workers Local 174 Retail Welfare Fund, and Trustees of and United Food and Commercial Workers Local 174 Commercial Health Care Fund as Amici Curiae.*

McLAUGHLIN, *Circuit Judge*:

Defendants Mario Cuomo *et al.* ("the State") and intervenors-defendants New York Conference of Blue Cross and Blue Shield Plans *et al.* appeal from a judgment of the United States District

Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

The district court held that certain components of New York's inpatient hospital reimbursement system are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), and the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914 (1988 & Supp. IV 1992). In particular, the district court invalidated three subsections of New York Public Health Law § 2807-c (McKinney Supp. 1993) imposing surcharges on the hospital rates for certain categories of payors, and not others. The district court also held that ERISA preempts ¶¶ 1, 2, 3, and 5 of Actuarial Letter No. 5, issued by New York's Department of Insurance.

The Travelers Insurance Company ("Travelers") cross-appeals, contending that the district court should also have granted its motion for summary judgment as to ¶ 4 of the Actuarial Letter, as well. We agree with Travelers and reverse that portion of the judgment which held that ¶ 4 is not preempted by ERISA. In all other respects, we affirm.

BACKGROUND

Eighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans. ERISA is the governing statute. ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills and usually carries excess liability coverage known as "stop-loss" coverage; (3) subscription to a health maintenance

organization ("HMO"); and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans (the "Blues").

Whereas ERISA regulates employee benefit plans of private employers, FEHBA establishes a comprehensive program to provide federal employees, their families, and federal retirees (collectively, "enrollees") with subsidized health care benefits. Under FEHBA, the United States does not act as an insurer, but, through the Office of Personnel Management ("OPM"), contracts with various insurance carriers to develop health care plans with varying coverages and costs. 5 U.S.C. § 8902. Prospective enrollees can select coverage from any one of the participating carriers in their region. 5 U.S.C. § 8905. Among the numerous plaintiffs in this action, only Mutual of Omaha Insurance Company underwrites and administers a FEHBA health benefit plan covering federal enrollees who receive inpatient hospital care in New York.

Any patient entering a hospital is placed in a category known as a diagnosis-related group ("DRG"), based on his symptoms and probable cost of treatment. The amount the hospital may charge for the patient's care is based on the DRG, not the actual cost of treatment. New York law provides that the DRG amount charged to a particular patient is then increased by a "payor factor," depending on the type of health care coverage the patient has. This, of course, results in a "differential" in the charges, depending on which type of health care coverage the patient has.

Since its enactment in 1988, New York Public Health Law § 2807-c(1)(b) has required that insurance carriers of patients covered by any form of health plan other than the Blues, an HMO, or government insurance such as Medicaid must pay 13% above the DRG rate. The 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New

Yorkers. In particular, the differential was meant to " 'level [the] playing field' " for the Blues "in their competition with commercial insurers." Joint Appendix at 649; Clyne Aff. ¶ 15. The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues.

The New York Omnibus Revenue Act of 1992 imposed two more surcharges: (1) an additional 11% surcharge on DRG payment rates charged to patients covered by commercial insurance, 1992 N.Y. Laws, ch. 55, § 348 (codified as amended at N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney Supp. 1993)); and (2) an assessment of up to 9% on HMOs which fail to enroll a target number of Medicaid-eligible persons. 1992 N.Y. Laws, ch. 55, § 346 (codified as amended at N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney Supp. 1993)). Unlike the basic 13% differential, the proceeds of the 11% surcharge are not kept by the hospital, but are paid into a statewide pool, which is then deposited into the State's general fund. HMOs, in contrast, must pay their 9% assessment directly into a statewide HMO pool, but it too ultimately winds up in the State's coffers.

The obvious effect of the 11% surcharge is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues. Unlike the 11% surcharge, however, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program.

Besides imposing surcharges, New York's Department of Insurance has issued "Actuarial Information Letter No. 5," regulating how self-insured plans obtain "stop-loss" insurance. The Letter: (1) permits a self-insured to obtain stop-loss insurance only if the plan provides its members with statutorily mandated services; (2) requires that self-insured plans provide beneficiaries with the right to a statutory conversion policy; and (3) requires

self-insured plans to afford members various protections in case the plan becomes insolvent.

In separate actions, several commercial insurers and insurance industry trade associations, including Travelers and the Health Insurance Association of America ("HIAA"), sued various New York State authorities for declaratory and injunctive relief, complaining that all three surcharges and the Actuarial Letter are preempted by ERISA, and the 13% and 11% surcharges are also preempted by FEHBA. The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, the "Blues Conference"), and the Hospital Association of New York State ("HANYS") intervened as defendants; the New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs. Thereafter, the parties cross-moved for summary judgment, and the district judge then consolidated the various actions.

The district court granted most of the relief that plaintiffs sought, holding that: (1) the Tax Injunction Act does not preclude an injunction against the 11% and 9% surcharges; (2) ERISA preempts all three surcharges; (3) FEHBA preempts the 13% and 11% surcharges; (4) plaintiffs' claims as to the 13% surcharge are not barred by the doctrine of laches; and (5) ¶¶ 1, 2, 3, and 5 of the Actuarial Letter are also preempted by ERISA. The court enjoined the defendants from enforcing the surcharges and the Actuarial Letter against the appropriate payors, but then stayed its ruling insofar as it enjoined the State from enforcing the 13% surcharge. Defendants appeal and plaintiff Travelers cross-appeals.

DISCUSSION

To promote clarity, we divide our analysis into four segments: (1) whether the district court had jurisdiction over these actions; (2) whether the equitable defense of laches raised by intervenor

HANYS has merit; (3) whether FEHBA preempts the 13% and 11% surcharges; and (4) finally, we address the chief argument advanced in support of reversal, ERISA preemption.

I. *Jurisdiction*

The Tax Injunction Act ("TIA") provides that federal district courts "shall not enjoin, suspend, or restrain the assessment . . . of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." 28 U.S.C. § 1341 (1988); *see Kraebel v. New York City Dep't of Hous. Preservation & Dev.*, 959 F.2d 395, 400 (2d Cir.) (TIA "bars federal injunctive challenges to state tax laws in federal courts."), *cert. denied*, 113 S. Ct. 326 (1992). This prohibition includes "declaratory as well as injunctive relief." *Barringer v. Griffes*, 964 F.2d 1278, 1280 (2d Cir. 1992).

The district court held that the TIA did not apply to the 11% and 9% surcharges, and therefore, it had jurisdiction. Two conditions must be satisfied to invoke the protection of the TIA: first, the surcharges must constitute "taxes,"[1] and second, the state remedies available to plaintiffs must be "plain, speedy and efficient." *See Kraebel*, 959 F. 2d at 400.

A. *Taxes*

The district court "assumed" that the 11% and 9% surcharges were "taxes" under the TIA, stating "to the extent that [these] [s]urcharges are paid into New York's General Fund, they appear to be taxes." 813 F. Supp. at 1000 & n.1 (citation omitted). Although there is no bright line between assessments that are taxes and those that are not, most courts agree that "[a]ssessments which are imposed primarily for revenue-raising purposes

[1]The Blues Conference does not argue that the 13% differential is a "tax" for good reason: its proceeds are retained by the hospitals and not deposited into the State treasury.

are 'taxes,' while levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 19 (D. Me. 1991) (collecting cases). In general, courts "have tended . . . to emphasize the revenue's ultimate use, asking whether it provides a general benefit to the public, of a sort often financed by a general tax, or whether it provides more narrow benefits to regulated companies or defrays the agency's costs of regulation." *San Juan Cellular Tel. Co. v. Public Serv. Comm'n*, 967 F.2d 683, 685 (1st Cir. 1992).

It is apparent that the 11% and 9% surcharges are taxes. Notwithstanding the primary purposes ascribed to the surcharges by the State, both raise revenue which is ultimately paid into the State's general fund. Thus, because the contested surcharges serve general revenue-raising purposes, they constitute "taxes" for purposes of the TIA. *See, e.g., Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991) (the word "tax" under the TIA "encompasses any state or local revenue collection device," including a city-assessed public utility "franchise fee" because the money raised was treated as part of the city's "general revenue"); *Butler*, 767 F. Supp. at 19 (nonrefundable jury fee required in Maine state courts "fits comfortably within [the] definition of a 'tax' under section 1341" because "the fees collected will be funneled into Maine's general fund, rather than being applied directly to the costs of jury trials.").

B. *State Remedy*

The district court found that plaintiffs did not have a "plain, speedy and efficient remedy" in New York state court "[b]ecause ERISA generally confers exclusive jurisdiction on the federal courts." 813 F. Supp. at 1001 (relying upon *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977)). Plaintiffs sued here as plan fiduciaries to enjoin a practice violating ERISA. Congress has divested the

state courts of jurisdiction over such claims. *See* 29 U.S.C. § 1132(e)(1) (1988); *see also Shofer v. Hack Co.*, 970 F.2d 1316, 1319 (4th Cir. 1992) (where ERISA claims are within the exclusive jurisdiction of the federal courts, state courts are plainly without jurisdiction). Thus, "[b]ecause the [New York] courts lack the jurisdiction to decide the plaintiffs' injunctive and declaratory ERISA claims, the plaintiffs are without a 'plain, speedy and efficient' remedy at state law." *Thiokol Corp. v. Department of Treasury, Revenue Div.*, 987 F.2d 376, 380 (6th Cir. 1993); *accord E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1102 (5th Cir.) (TIA is "inapplicable" in an ERISA setting), *cert. denied*, 112 S. Ct. 585 (1991).

Accordingly, we conclude that the district court did not err in finding that the state remedies available to plaintiffs were inadequate, and thus it had jurisdiction over plaintiffs' claims.

II. *Laches*

New York's complex reimbursement system has had a differential among various payors since the late 1970s. A statutory differential has existed since 1983. Hence, intervenor HANYS contends that plaintiffs' current challenge to the 13% differential is barred by laches.

Laches is an equitable defense that applies when "a plaintiff unreasonably delayed in initiating an action and a defendant was prejudiced by the delay." *Robins Island Preservation Fund, Inc. v. Southold Dev. Corp.*, 959 F.2d 409, 423 (2d Cir.) (citations omitted), *cert. denied*, 113 S. Ct. 603 (1992). We review a district court's application of the laches doctrine for an abuse of discretion, *see King v. Innovation Books, Div. of Innovative Corp.*, 976 F.2d 824, 832 (2d Cir. 1992), and we find no abuse here.

In our view, there was a legitimate reason for plaintiffs' delay in mounting this challenge. *See Stone v. Williams*, 873 F.2d 620,

624 (2d. Cir.) ("[I]t is the reasonableness of the delay rather than the number of years that elapsed which is the focus of the [laches] inquiry."), *cert. denied*, 493 U.S. 959, *and vacated on other grounds*, 891 F.2d 401 (2d Cir. 1989), *cert. denied*, 496 U.S. 937 (1990). Almost ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), we rejected a claim that ERISA preempted New York's regulatory scheme governing hospital rates.

Rebaldo, while probably distinguishable, created little hope for the success of future challenges to New York's reimbursement system. Prospects of success improved only recently because of Supreme Court cases which, as will be discussed *infra*, undermine *Rebaldo*. Immediately after *Rebaldo*, instead of challenging the 13% differential in court, plaintiffs changed their tactics and sought a legislative remedy, instead. Only when these legislative efforts failed in 1992 with the enactment of an additional 11% surcharge did they sue the State. This is not a tableau of unreasonable delay. Accordingly, we find no error in the district court's rejection of the laches defense.

III. *FEHBA Preemption*

Adopted as part of the Omnibus Budget Reconciliation Act of 1990 ("OBRA"), Pub. L. No. 101-508, § 7002(c), 104 Stat. 1388, 1388-330 (1990) (codified without title of § 7002(c) at 5 U.S.C. § 8909(f) (Supp. IV 1992) (amending 5 U.S.C. § 8909 (1988)), FEHBA's preemption provision is contained in § 8909(f)(1):

> No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

The district court found this provision ambiguous. Finding the statute's legislative history equally unenlightening, it invoked the teachings of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984) (absent clear congressional intent, district courts should defer to implementing agency's interpretation of a federal statute, as long as that interpretation is reasonable). Thus, the court turned to OPM for guidance. It concluded that OPM's determination that the surcharges are preempted under § 8909(f)(1) was a reasonable construction of the statute and deferred to that interpretation by holding FEHBA preempted the 13% and 11% surcharges.

On appeal, defendants renew the argument that "the language of the statute as well as its legislative history are unambiguous, and reflect Congress' clear intent that FEHBA preemption apply only to state premium taxes." 813 F. Supp. at 1010; *see* 48 C.F.R. § 1652.216-71 (1992) (defining "premium taxes" as those "imposed on FEHB premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico"). They point to the statute's legislative history and the title of § 7002(c) -- "EXEMPTION FROM STATE PREMIUM TAXES" -- and conclude that § 8909(f)(1) is targeted only at premium taxes, and not the surcharges here. We are not persuaded.

We start by looking at the plain language of a statute to interpret its ordinary common meaning. *See Connecticut Nat'l Bank v. Germain*, 112 S. Ct. 1146, 1149 (1992) ("courts must presume that a legislature says in a statute what it means and means in a statute what it says"). "If the words of a statute are unambiguous, judicial inquiry should end, and the law interpreted according to the plain meaning of its words." *Aslanidis v. United States Lines, Inc.*, 7 F.3d 1067, 1073 (2d Cir. 1993). In our view, the language of § 8909(f)(1) is sufficiently clear to reveal congressional intent. *See Ardestani v. INS*, 112 S. Ct. 515, 520 (1991) (strong presumption that plain language of statute expresses legislative intent).

By its terms, 5 U.S.C. § 8909(f)(1) prohibits [1] every state or local "tax, fee, or other monetary payment" [2] imposed, "directly or indirectly," on a "carrier or an underwriting or plan administration subcontractor of an approved [FEHBA] health benefits plan," [3] "with respect to any payment made from the Fund." Defendants do not dispute that the 13% and 11% surcharges satisfy the first two requirements for preemption: the surcharges are a state-imposed "tax, fee, or other monetary payment," and they are imposed "directly or indirectly" on carriers offering FEHBA plans. The controversy, therefore, is over the third one -- the requirement that the tax is imposed "with respect to any payment made from the Fund."

Under FEHBA, the federal government and individual enrollees make "contributions" which are then deposited into the Employees Health Benefits Fund (the "Fund") in the United States Treasury. 5 U.S.C. §§ 8906, 8909 (1988 & Supp. IV 1992). The Fund is administered by OPM. *Id.*

OPM contracts with various insurance carriers, and through various health benefit plans the carriers provide, pay for, or reimburse the cost of health services for enrollees. 5 U.S.C. §§ 8901(6), 8901(7), and 8902(a) (1988). In turn, OPM creates a letter of credit ("LOC") account for each experience-rated plan,[2] and the LOC is maintained in the Treasury as part of the Fund. Each carrier draws against its LOC account on a "checks-pre-

[2]Contribution rates for an experience-rated plan are based on the plan's actual paid claims, administrative expenses, and other allowable "retentions." *See* 48 C.F.R. § 1602.170-6 (1992) (defining "[e]xperience rate"). In contrast, a "*[c]ommunity rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan." 48 C.F.R. § 1602.170-2(a) (1992).

Because the FEHBA preemption issue in this case involves only experience-rated plans, we need not reach the issue as to community-rated plans.

sented" basis for amounts paid by the carrier as FEHBA claims or expenses. 5 U.S.C. § 8909(a) (Supp. IV 1992); 48 C.F.R. § 1632.170(b)(2) (1992). This requires carriers to pay for covered hospital treatment from their own resources, and then get reimbursed by drawing against their LOC. *Cf.* 48 C.F.R. § 1632.170(b)(2) ("[D]rawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.").

Given this scheme of payment and reimbursement, and mindful of how the two reserves required for each experience-rated plan work, *see* 5 U.S.C. § 8909(b)(2) (Supp. IV 1992); 5 C.F.R. §§ 890.503(c)(1)-(2) (1993) ("contingency" reserve); 5 C.F.R. § 890.503(c)(3) (1993) ("carrier" reserve), the preemption issue is not a difficult one. The 13% and 11% surcharges are, indeed, imposed "with respect to any payment made from the Fund" because the amount drawn by experience-rated carriers from their LOC accounts, which are part of the Fund, is based in part on the amount of the surcharge. As already noted, carriers first pay hospital bills from their own funds, then draw from their LOC accounts to replenish their depleted funds. Because payments from the Fund are directly affected by what the hospitals charge for their services, and because the surcharges increase the amounts carriers draw from the Fund, the surcharges are clearly imposed "with respect to . . . payment[s] made from the Fund." Accordingly, they are preempted.

Despite this straightforward construction of § 8909(f)(1), defendants urge us to reject it because our interpretation is repugnant to the general aims of FEHBA. They believe that there is a clearly expressed legislative intention that is contrary to the language of the statute. *Cf. United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242 (1989) ("The plain meaning of legislation should be conclusive, except in the 'rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters.' " (citation omitted)).

In plumbing the legislative history of § 8909(f)(1), defendants selectively ignore legislative policies that run counter to their interpretation of the statute. Section 8909(f)(1) was enacted as part of OBRA, the central purpose of which was to reduce government expenditures. *See* H. Rep. No. 101-881, 101st Cong., 2d Sess. 169 (1990), *reprinted in* 1990 U.S.C.C.A.N. 2017, 2177. For its part, § 8909(f)(1) was designed to reduce expenditures from the Fund by preventing states from charging taxes on health care reimbursements drawn by carriers from the Fund. *Id.* at 173, *reprinted in* 1990 U.S.C.C.A.N. at 2181. To adopt defendants' crabbed view of preemption would undermine this revenue-saving purpose.

Defendants cite numerous excerpts from congressional committee reports where § 8909(f)(1) is characterized as a restriction on "premium taxes." This exercise is singularly unenlightening, however, because it remains obscure what the various members of Congress meant when they referred to "premium taxes" in discussing § 8909(f)(1). We also note that defendants' reliance on the title to § 7002(c) of OBRA containing § 8909(f) as an amendment to FEHBA is misplaced. Defendants simply ignore that the focal point of this controversy is FEHBA § 8909(f)(1), and not OBRA § 7002(c).

Finally, defendants are piqued that the district court deferred to OPM's current interpretation of the preemption issue. (This interpretation is set forth in the government's *amicus* brief and affidavits, and was first solicited by the State from OPM (in opinion letters) before this action even began.) Defendants argue that the district court ignored an earlier OPM regulation limiting the scope of § 8909(f) to "premium taxes," 48 C.F.R. § 1631.205-41 (1992), and instead improperly deferred to OPM's current interpretation which defendants characterize as " 'agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice.' " State's Brief at 44 (quoting *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212 (1988)).

Even if we agreed that the language of § 8909(f)(1) is ambiguous and its legislative history unilluminating, we would still affirm the district court's judgment, with its reliance on OPM's *amicus* position. As a preliminary matter, the district court did not defer to an "agency litigating position"; rather, it deferred to OPM's administrative interpretation of § 8909(f)(1), made before the government entered this litigation and offered in response to a request from New York itself.

OPM in its *amicus* brief to this Court asserts that 48 C.F.R. § 1631.205-41 uses "premium taxes" as a shorthand description of the taxes covered by 5 U.S.C. § 8909(f)(1), not in the narrow sense urged by defendants. The regulation stresses, in OPM's view, the broad sweep of § 8909(f), interpreting it to apply to "*all* payments directed by States or municipalities, regardless of how they may be titled, to whom they must be paid, or the purpose for which they are collected," including "*all* forms of direct and indirect measurement of FEHBP premiums, *however modified* . . . ." 48 C.F.R. § 1631.205-41 (emphasis added). Like the district court, we too will defer to OPM's interpretation of its own regulation unless it "is . . . plainly erroneous or inconsistent with the language of the regulation." *Federal Labor Relations Auth. v. United States Dept. of Veterans Affairs*, 958 F.2d 503, 514 (2d Cir. 1992) (citing *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989)). We cannot say it is unreasonable to interpret § 1631.205-41 as OPM does.

Accordingly, the New York statutes imposing the 13% and 11% surcharges are preempted by FEHBA.

IV. *ERISA Preemption*

Whether a particular state statute is preempted by ERISA is a question of statutory interpretation, as informed by congressional intent. With understated irony, the Supreme Court has described the ERISA section at issue here as "not a model of legislative

drafting." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). In truth, it is a veritable Sargasso Sea of obfuscation:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .
>
> **(b) Construction and application**
>
> . . . .
>
> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be *deemed* to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a)-(b)(2)(B) (1988) (emphasis added).

The opening paragraph is the *preemption* clause. The next paragraph [(b)(2)(A)] is the *saving* clause. And the final paragraph [(b)(2)(B)] has come to be known as the *deemer* clause. *See FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990).

Setting sail, we begin with the observation that ERISA is a comprehensive federal statutory scheme regulating "private employee benefits plans, including both pension and welfare plans." *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 582 (1992). "A 'welfare plan' is defined . . . to include, *inter alia*, any 'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.' " *Id.* (quoting 29 U.S.C. § 1002(1)). While the statute does not mandate particular benefits, it " 'sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for . . . welfare plans.' " *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting *Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85, 91 (1983) (citation omitted)).

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a) (the preemption clause). This sweeping provision is not without qualification and, pertinent to this case, excepts from preemption those state laws that "regulate insurance," 29 U.S.C. § 1144(b)(2)(A) (the saving clause), except as further provided in the deemer clause, stating that an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or "engaged in the business of insurance . . . for purposes of any [state law] purporting to regulate" insurance companies or insurance contracts. 29 U.S.C. § 1144(b)(2)(B); *see FMC Corp.*, 498 U.S. at 58.

The district court concluded that all the surcharges, as well as ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" employee benefit plans within the meaning of ERISA's preemption clause. The court also found that the surcharges are not preserved by the saving clause as laws that "regulate insurance;" and, without

considering whether the Actuarial Letter regulates insurance, the court also concluded that the deemer clause precluded any state regulation of self-funded plans. Accordingly, the district court held that ERISA preempted the three surcharges and also ¶¶ 1, 2, 3, and 5 of the Actuarial Letter. For the reasons set forth below, we substantially agree.

The Supreme Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of [the preemption clause] 'if it has a connection with or reference to such a plan.' " *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97) (citations omitted). The term "relate to" is to be accorded "its broad common-sense meaning," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), thereby giving "effect to the 'deliberately expansive' language chosen by Congress." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans or the effect is only indirect," *Ingersoll-Rand*, 498 U.S. at 139, and even if the law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins.*, 471 U.S. at 739. Accordingly, we have held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush Inc.*, 959 F.2d 6, 9 (2d Cir. 1992).

On the other hand, the Court has also recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 100 n.21 (1983), "as is the case with many laws of general applicability." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law under which creditors can garnish ERISA welfare benefits not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987)

(law requiring companies to make lump-sum severance payments when closing a plant not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (application of escheat law to ERISA-covered benefit checks and drafts issued but not collected or presented for payment by beneficiaries not preempted), *cert. denied*, 493 U.S. 811 (1989).

On appeal, defendants contend that "the [s]urcharges do not 'relate to' ERISA plans within the meaning of ERISA's preemption clause because they are laws of general application, which have only a peripheral impact on the plans." 813 F. Supp. at 1005. In making this argument, defendants rely on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) and fault the district court for its conclusion that *Rebaldo* "has been abrogated by later Supreme Court cases." 813 F. Supp. at 1005.

Rebaldo held that ERISA did not preempt certain New York regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals. In rejecting this challenge, we initially found that "a state law must '*purport*[] to regulate, . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" of ERISA. *Rebaldo*, 749 F.2d at 137 (quoting 29 U.S.C. § 1144(c)(2)) (emphasis added). *Rebaldo* went on to hold that the impact of New York's regulations on ERISA benefit plans was too tenuous, remote, and peripheral to require preemption. *Id.* at 138. Six years later, in *Ingersoll-Rand*, 498 U.S. at 141, the Supreme Court expressly rejected the notion that Congress intended to limit ERISA's preemptive effect to state laws *purporting* to regulate plan terms and conditions. *See Smith*, 959 F.2d at 9 & n.3 (following *Ingersoll-Rand*, rejecting "purports to regulate" standard). Despite *Ingersoll-Rand*, defendants continue to argue that *Rebaldo*'s analysis of what triggers ERISA preemption is still controlling.

We have little difficulty agreeing with the district court that *Rebaldo*'s fundamental premise was rejected by the Supreme Court. In our view, *Rebaldo*'s entire analysis is poisoned by its

discredited belief that ERISA's preemption clause is targeted only at state laws that "purport to regulate" plan terms and conditions. Therefore, we conclude that defendants' reliance on *Rebaldo* is misplaced.

A. *The Surcharges: Preemption*

Defendants maintain that the district court erred in concluding that the challenged statutes' indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan. We disagree. While the challenged statutes do not refer to ERISA plans, *see Mackey*, 486 U.S. at 831 (statute need not specifically mention ERISA plans to be preempted), our examination of the surcharges indicates that they satisfy the less stringent "connection with" standard embraced in *Ingersoll-Rand*.

The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans. *See, e.g., National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir.) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S. Ct. 406 (1992); *In re Michigan Carpenters Council Health & Welfare Fund*, 933 F.2d 376, 382-83 (6th Cir.) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S. Ct. 585 (1991); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (Connecticut tax on ERISA benefits preempted since it

may encourage use of traditional insurance rather than ERISA-covered plans); *Morgan Guar. Trust Co. v. Tax Appeals Tribunal of Dep't of Taxation & Finance*, 80 N.Y.2d 44, 51, 587 N.Y.S.2d 252, 256, 599 N.E.2d 656, 660 (1992) (New York real estate gains tax preempted as applied to sale of ERISA property because tax will influence plans' investment strategy).

The surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. Under similar circumstances, the Fifth Circuit held that a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991). The court found that the tax was related to ERISA plans because: "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *Id.* at 1103.

As in *E-Systems*, the surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (New York Labor Law governing wage requirements was preempted where it required employers to pay certain benefits, because " 'private parties, not the Government, control the level of benefits' " under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)), *cert. denied*, 496 U.S. 912 (1990); *cf. Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991) ("Like all the factors considered, . . . simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry."), *cert. denied*, 112 S. Ct. 2305 (1992).

In making its finding that the surcharges are related to ERISA, the district court focused on plaintiffs' claims that they would pass along the higher costs associated with the surcharges, which

might in turn lead plans to reduce their level of service or benefits. Defendants and the Department of Labor as *amicus* contend that the indirect and inevitably speculative economic impact of the challenged statutes *alone* does not justify a finding of preemption. They argue that the Supreme Court has never held that indirect economic impact, standing alone, is sufficient to justify a finding of preemption. *See, e.g., Mackey*, 486 U.S. at 830-41 (indirect economic effect of state garnishment law not enough to warrant preemption); *see also Aetna Life*, 869 F.2d at 146 ("where a state statute of general application 'does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.' " (quoting *Rebaldo*, 749 F.2d at 139)).

The Blues Conference, in particular, relies on *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993) ("The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption."). There, Judge Martin rejected an ERISA plan's challenge to New York's Health Facility Assessment ("HFA") because its economic impact on the plan was *de minimis*. The court distinguished *Morgan Guaranty Trust*, 80 N.Y.2d 44, 587 N.Y.S.2d 252, 599 N.E.2d 656, on the ground that the New York case involved a "substantial" tax of 10% of the consideration received for the realty sold therein, as opposed to the HFA of 0.6% of gross receipts to which the HFA was applicable. Further, Judge Martin in *NYSA-ILA* explicitly compared the result Judge Freeh reached in this case, with its surcharges of 13%, 11%, and 9% on hospital DRGs. *See NYSA-ILA*, 1993 WL 51146, at *4. Thus, the *NYSA-ILA* court recognized that a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play.

In sum, Judge Freeh properly found that the three surcharges "relate to" ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and adminis-

tration.[3] Accordingly, the statutes at issue here are preempted -- unless they are salvaged by ERISA's saving clause as a law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A).

B. *The Surcharges: Saving Clause*

To determine whether a state law regulates insurance within the meaning of the saving clause, a court must first "consider the

[3]To the extent that our holding conflicts with *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir.), *cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 383 (1993), we decline to follow it. In that case, several self-insured union employee welfare benefit plans sued numerous New Jersey hospitals and various New Jersey State authorities for injunctive relief, complaining that New Jersey's statutory scheme for setting hospital rates was preempted by ERISA. The rate-setting statute at issue imposed additional surcharges on DRG rates to compensate hospitals for providing "uncompensated care" and treating Medicare patients, and granted discounts to certain classes of payors.

The Third Circuit held that the rate-setting statute "does not relate to the plans in a way that triggers ERISA's preemption clause." *Id.* at 1191. In brief, the court found that the connection between the statute and ERISA plans was too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans," *id.* at 1192, and the statute's "indirect ultimate effect of increasing plan costs" places it beyond the scope of ERISA preemption. *Id.* at 1193-95.

Ironically, in reaching its conclusion, the Third Circuit relied heavily on our opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). As we discuss above, however, we believe that decisions of the Supreme Court since *Rebaldo* have significantly eroded the premise upon which *Rebaldo* was decided. More generally, however, we also believe that the Third Circuit reads ERISA's preemption clause too narrowly. *See United Wire*, 995 F.2d at 1196-1203 (Nygaard, J., dissenting).

'common-sense view' of the term 'regulates insurance' which suggests that 'in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be *specifically* directed toward that industry." *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). The court must next assess whether the law satisfies the three criteria developed for determining whether a practice constitutes "the business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1988 & Supp. IV 1992).[4] *See Pilot Life*, 481 U.S. at 48. Those criteria are: " '*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

Applying these tests, we conclude, first of all, that the 13% and 11% surcharges do not "regulate insurance" within the meaning

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[4]The McCarran Act was enacted in 1945 to help resolve federalism concerns over the roles of federal and state governments in regulating insurance. Now known as the McCarran-Ferguson Act, it provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

of the saving clause.[5] Our common-sense inquiry reveals that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates. Although the surcharge laws provide for different payment rates based on whether a patient is uninsured, covered by an HMO, a commercial insurer or a self-insured health plan, they do not address matters typically within the purview of state insurance regulations such as: the solvency and qualification of an insurance company's management, the sale and advertising of insurance, rates and the content of insurance policies. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-28 & n.2 (1985).

Defendants argue that the 13% and 11% surcharges are designed to affect the insurance marketplace by giving the Blues a

[5]The Department of Labor ("DOL") argues that the saving clause validates all three surcharges; the Blues Conference argues that it preserves the 13% and 11% surcharges; and the State invokes it only as to the 11% surcharge. Although both the DOL and the Conference claim that HMOs are insurers for purposes of the saving clause, only the DOL contends that the 9% assessment on HMOs comes within ERISA's saving clause. The DOL argues that HMOs are engaged in the "business of insurance" when they reimburse hospitals for providing services to their subscribers. While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state--licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." 813 F. Supp. at 1007.

competitive advantage over commercial insurers, self-insured funds, and a number of other players in the marketplace -- and thus may be characterized as the regulation of insurance. This argument, however, confuses laws regulating the "business of insurance" with laws regulating hospital rates that have an effect on the "insurance marketplace." Although the surcharge laws clearly have some impact on insurance companies, this alone is not enough. As the Supreme Court has made clear in interpreting § 2(b) of the McCarran-Ferguson Act, there is a difference between the "business of insurance" and the "business of insurers." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210-17 (1979).

In our view, defendants' arguments proceed from an impermissibly broad reading of the saving clause. Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans, *see, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life*, 481 U.S. at 47-48, and installed the saving clause to preserve only those state laws precisely directed at the insurance business. The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.

Nor do the McCarran-Ferguson factors suggest otherwise. The Blues -- unlike commercial carriers -- offer health insurance to anybody, no matter who they are or what physical shape they are in. As the insurer of last resort, the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers. Most high risk policyholders, therefore, are insured under the Blues. Because the 13% and 11% surcharges are designed to encourage ERISA plans -- with generally healthier persons -- to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs.

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), does not alter this conclusion. There, the Supreme Court ruled that Blue Shield's arrangement with certain pharmacies to charge Blue Shield's insureds only $2 for every prescription drug did not constitute the "business of insurance" under McCarran-Ferguson. As noted by the district court here, "[t]he Supreme Court held that the agreements between Blue Shield and the participating pharmacies did not spread any risk because those agreements merely reduced Blue Shield's costs for fulfilling an obligation which Blue Shield had already assumed." 813 F. Supp. at 1008 n.15 (citing *Royal Drug*, 440 U.S. at 212-14). Here, the challenged surcharges do not merely raise the cost of inpatient hospital services, but play a significant role in encouraging ERISA plans to shift to the Blues. Thus, unlike *Royal Drug*, the surcharges here can be said to have "the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48 (quoting *Union Labor Life Ins.*, 458 U.S. at 129).

The 13% and 11% surcharges, however, fail to satisfy the remaining two McCarran-Ferguson factors. These surcharges do not regulate any practice that is integral to the insurer-insured relationship. As we noted on an earlier occasion, the essence of the second McCarran-Ferguson factor is whether a statute "dictate[s] any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." *Howard*, 901 F.2d at 1159. True, the surcharges here were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues; but they do not directly change any of the terms, conditions or scope of coverage in commercial insurance contracts. Rather, because the surcharges expressly regulate hospital rates, they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds.

Finally, the surcharges are not "limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 49 (quoting *Union Labor Life Ins.*, 458 U.S. at 129). In *Howard*, a provision of the New York Insurance Law required that either the insurer or the employer (in certain circumstances) give notice of conversion privileges upon termination of employment. *Id.* at 1156. We found that this provision was not a regulation of insurance. *Id.* at 1159. We noted that since the notice could be given by either the employer or the insurer, the law was not limited to entities within the insurance industry. *Id.* Here, the surcharges set rates that hospitals must charge patients, and thus involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds. Thus, the third McCarron-Ferguson factor is not satisfied.

Accordingly, because of our common-sense determination that the surcharges do not regulate insurance, and because two of the three McCarran-Ferguson factors are not satisfied, we agree with the district court that the 13% and 11% surcharges are not preserved by the saving clause. Accordingly, the New York statutes imposing the surcharges are preempted by ERISA.[6]

C. *The Actuarial Letter*

Self-insured employee benefit plans and their employer sponsors, including the Sheridan Catheter Plan (on whose behalf Travelers challenges the Actuarial Letter), often purchase stop-loss insurance to protect themselves against excess or catastrophic losses. Unlike traditional group-health insurance, stop-loss insurance is akin to reinsurance in that it does not provide coverage directly to plan members or beneficiaries. Rather, most

[6]We also agree with the district court that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law," 813 F. Supp. at 1007, and is thus preempted by ERISA. *See* discussion *supra* note 4.

stop-loss policies (and the policy issued to the Sheridan Catheter Plan here) provide coverage to the plan itself if the total amount of claims paid by the plan exceeds the amount of anticipated claims by a specified sum.

The Actuarial Letter under attack purports to regulate the terms of such stop-loss insurance contracts. Its relevant provisions follow:

> 1. The insurer must undertake to ensure that statutorily mandated benefits be covered under the employer's plan;
>
> 2. The insurer must agree to ensure that statutory conversion policies be provided, either by them or by another insurer;
>
> 3. Notice must be given to employees if and when the insurer becomes liable for runoff claims. . . .
>
> 4. The insurer should maintain full runoff reserves. If the policyholder holds his own reserves, the insurer's claim reserves are to be replaced by a terminal premium payable immediately upon termination. . . .
>
> 5. The insurer must take full responsibility for the payment of all employer plan claims incurred but not yet paid at the date of termination of the policy . . .

The district court properly found that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" an employee benefit plan for purposes of ERISA's preemption clause. Paragraphs 1 and 5 on their face make specific "reference to" an employee benefit plan, and ¶¶ 2 and 3 clearly have a "connection with" such plans. *See Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97). ERISA therefore preempts ¶¶ 1, 2, 3, and 5 of the

Actuarial Letter unless they find salvation in ERISA's saving clause as a law that regulates insurance, and even that salvation will be denied unless the employee benefit plan can escape the orbit of § 1144(b)(2)(B) refusing to deem such a plan "to be an insurance company or other insurer."

The district court concluded that ¶¶ 1, 2, 3, and 5 were preempted and the saving clause for insurance regulations did not save them because, under the deemer clause, self-insured employee benefit plans are not deemed to be "an insurance company or other insurer . . . ." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). The Department of Labor and Travelers, while agreeing with this result, suggest that the district court should not have reached the deemer clause without first considering whether ¶¶ 1, 2, 3, and 5 regulate insurance at all, within the meaning of the saving clause. We agree. Accordingly, we affirm the district court's holding on a different ground: ¶¶ 1, 2, 3, and 5 are not saved from preemption because those paragraphs do not regulate insurance within the meaning of the saving clause.

As already discussed, in order to fall within the saving clause, the state law must constitute the regulation of insurance from a common-sense point of view and must also satisfy the McCarran-Ferguson factors. *See Pilot Life*, 481 U.S. at 48-49. The challenged provisions of the Actuarial Letter do neither.

Pilot Life's common-sense test does not validate every conceivable restriction on the sale of insurance contracts under the rubric of regulation of insurance. *See Howard*, 901 F.2d at 1158. We conclude that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter use the regulation of stop-loss coverage as a pretext to regulate the terms of self-funded ERISA plans.

In ¶ 1 of the Actuarial Letter, the State permits a self-insured plan to obtain stop-loss coverage only if the plan provides its members and beneficiaries with the full panoply of benefits

mandated by New York's Insurance Law. Paragraph 2 requires the plan to provide its beneficiaries with the right to a statutory conversion policy. Paragraphs 3 and 5 require the plan to afford its members a host of protections in case the plan becomes insolvent. Because the conditions imposed by the Actuarial Letter are not limited just to the stop-loss layer of insurance but apply generally to the entire plan, we conclude that ¶¶ 1, 2, 3, and 5 of the Letter do not, as a practical matter, regulate just insurance.

Furthermore, the challenged provisions of the Actuarial Letter do not satisfy the McCarran-Ferguson criteria. First of all, ¶¶ 1, 2, 3, and 5 do not have the effect of transferring or spreading risk between a self-funded plan and its stop-loss insurer but, instead, require the self-insured plan to provide additional benefits and protections to the plan's members and beneficiaries.

Second, the challenged provisions are not an integral part of a self-funded plan's relationship with its stop-loss insurer. Paragraph 1, for example, focuses squarely on the self-funded plan's relationship with its participants, not with the stop-loss insurer. Because employees are not insured under the terms of the stop-loss policy, requiring the stop-loss insurer to notify such individuals, as ¶ 3 does, is not an integral part of the insurance relationship. Likewise, because ¶ 5's purpose is to protect employees, who are not insured under the stop-loss contract, that paragraph is not an integral part of the insurance relationship between the plan and its stop-loss insurer.

Finally, ¶¶ 1, 2, 3, and 5 are not limited to insurance entities. Paragraph 1 is aimed directly at sponsors of self-funded plans. By requiring the sponsoring employer to provide conversion rights through another insurer if the stop-loss insurer does not provide such rights, ¶ 2 is aimed directly at employers who are not part of the insurance industry. *See Howard*, 901 F.2d at 1159 (state law requiring either insurer or employer to notify covered employees of conversion rights was not "limited to entities within the insur-

ance industry"). Likewise, ¶ 3 states specifically that the Department of Insurance "will accept a policy provision which requires the employer to pass along [the notice] material." Thus, it too is not "limited to entities within the insurance industry." *See id.*

In sum, the challenged provisions of the Actuarial Letter satisfy neither the common-sense test nor the McCarran-Ferguson factors. Consequently, they do not fall within the saving clause and are preempted.

The district court also held that ¶¶ 4, 6, and 7 of the Actuarial Letter do not "relate to" ERISA plans and, accordingly, did not reach the saving clause argument as to those paragraphs. On cross-appeal, Travelers argues that the district court erred to the extent it found that ¶ 4 does not "relate to" ERISA plans.[7] We agree and therefore reverse that part of the district court's decision holding that ¶ 4 is not preempted.

Paragraph 4, like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, is directed at the purchasers of stop-loss coverage which are primarily ERISA plans. It effectively requires the "policyholder" -- which is an ERISA plan -- either to purchase insurance for "run-off claims" or maintain significant reserves of its own. This alone merits a finding that ¶ 4 has a "connection with" employee benefit plans and, therefore, is "relate[d] to" such plans for purposes of ERISA's preemption clause because stop-loss protection will guarantee that benefits are paid to employees even if the carrier suffers catastrophic losses.

Reaching the saving clause argument, we conclude that ¶ 4 does not "regulate insurance" and therefore is not saved from ERISA preemption. In our view, ¶ 4 attempts to regulate, through the self-loss insurer, the benefits offered by and the administrative functioning of self-funded ERISA plans. Paragraph 4 is

[7]The district court's findings as to ¶¶ 6 and 7 are not now challenged by Travelers or the Department of Labor.

similar to the other challenged paragraphs. Like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, ¶ 4 does not fall within the saving clause and is, therefore, preempted.

We hold, therefore, that the five challenged paragraphs do not regulate insurance within the meaning of the saving clause and, accordingly, are preempted. We affirm the district court's ruling as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

CONCLUSION

To sum up: We find that the district court properly found that plaintiffs' challenges to the 11% and 9% surcharges are not barred by the TIA. Nor is their challenge to the 13% differential barred by laches. Further, the district court properly held that the three surcharges are preempted by ERISA. Finally, we affirm the court's decision as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

Accordingly, the judgment of the district court is affirmed in part, reversed in part, and the district court is directed to enter judgment consistent with this opinion.

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

THE TRAVELERS INSURANCE COMPANY,

v.

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, LORNA MCBARNETTE, in her Official Capacity as Acting Commissioner of Health of the State of New York, and SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York.

Case No. 92 Civ. 3999 (LJF)

Summons in a Civil Action, filed June 2, 1992

TO:

Salvatore R. Curiale
Superintendent of Insurance
Department of Insurance
160 West Broadway
New York, NY 10013

Mario M. Cuomo
Executive Chamber
State Capitol
Albany, NY 12224

Lorna McBarnette
Acting Commissioner
New York State
Dept of Health
Empire State Plaza
Albany, NY 12237

YOU ARE HEREBY SUMMONED and required to file with the Clerk of this Court and serve upon Plaintiff's Attorney

Windels, Marx, Davies & Ives
156 West 56th Street
New York, NY 10019

an answer to the complaint which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

JAMES M. PARKISON
Clerk

• • •

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Complaint, filed June 2, 1992

[Travelers Ins. Co. v. Cuomo]

Plaintiff The Travelers Insurance Company ("The Travelers"), by its attorneys, Windels, Marx, Davies & Ives, for its complaint in this action, respectfully alleges as follows:

JURISDICTION AND VENUE

1. This is an action for declaratory relief pursuant to 28 U.S.C. §2201 and Rule 57 of the Federal Rules of Civil Procedure, and injunctive relief pursuant to 28 U.S.C. §2202.

2. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331 and 29 U.S.C. §1132 (e)(1) in that The Travelers is a person empowered to bring a civil action under Section 502 (a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1132 (a)(3), and seeks a declaration that certain provisions of New York law are preempted under Section 514 (a) of ERISA, 29 U.S.C. §1144(a). This Court also has jurisdiction of this action under 28 U.S.C. §1332 (a)(1) in that this action is between citizens of different states and the amount in controversy exceeds $50,000.

3. Venue is proper in this judicial district pursuant to 28 U.S.C. §1391 (b) and 29 U.S.C. §1132 (e)(2) in that defendant Curiale resides in this judicial district.

THE PARTIES

4. Plaintiff The Travelers is a corporation organized and existing under the laws of the State of Connecticut with its principal place of business in the State of Connecticut. The Travelers is authorized and licensed to do business in the State of New York.

5. Defendant Mario M. Cuomo is the Governor of the State of New York and is a citizen of the State of New York.

6. Defendant Lorna McBarnette is the Acting Commissioner of Health of the State of New York and is a citizen of the State of New York.

7. Defendant Salvatore R. Curiale is the Superintendent of Insurance of the State of New York and is a citizen of the State of New York. Defendant Curiale's official residence is 160 West Broadway, New York, New York 10013.

ALLEGATIONS COMMON TO ALL COUNTS

8. The Travelers and its affiliated and subsidiary companies constitute one of the world's largest multi-line insurance, financial and health services institutions. Among other services, The Travelers provides group accident and health insurance. The Travelers also provides claims administration for employer plans which are fully self-insured or primarily self-insured with excess risk insurance, which is known in the insurance industry as stop-loss coverage. With regard to the handling of claims for many such plans, The Travelers is a fiduciary within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

9. The Travelers has been actively engaged in underwriting group insurance plans for over 75 years, and is a licensed group insurer in all 50 states, the District of Columbia, Puerto Rico, the

Virgin Islands and the Bahamas. The Travelers markets group accident and health insurance through group contracts to employers, employer associations and trusts, and other organizations ranging in size from small local employers to large multinational corporations.

10. The vast majority of employers purchasing either claims administration services or group accident and health insurance from The Travelers are subject to ERISA and its enforcement provisions as administered by the U. S. Department of Labor.

11. Many of the employers purchasing either claims administration services or group accident and health insurance from The Travelers operate in more than one state.

12. In New York State, The Travelers provides either claims administration services or group accident and health insurance to over 430,000 employees and dependents covered by ERISA plans. The Travelers provides the above services or insurance in connection with 4,429 separate ERISA plans.

13. The premiums charged by The Travelers for group insurance coverage reflect assumptions as to claims, investment returns and expenses, and a profit margin. As the costs of the medical treatment covered by The Travelers under a group policy increase, The Travelers passes the cost through to the employer by increasing the premium. Similarly, in the case of a self-insured plan, as the cost of the covered treatment increases, the amount of the claims administered by The Travelers and paid by the employer increases.

14. The group accident and health insurance benefits provided by The Travelers under a typical group insurance policy include reimbursement of hospital, surgical and medical expenses, including coverage for inpatient hospital care. With regard to inpatient hospital care, the employee usually executes an

assignment or authorization to pay, and based upon such direction, The Travelers will usually pay directly to the hospital providing the services the amount charged by the hospital for inpatient care, subject to the terms of the policy. Under a typical group insurance policy, The Travelers provides insurance benefits directly to the employee and his dependents.

15. The Travelers also provides stop-loss coverage to self-insured group health plans. The stop-loss policies issued by The Travelers usually provide either individual stop-loss coverage, aggregate stop-loss coverage or both. Under an individual stop-loss provision, The Travelers provides coverage only if the benefits paid by the plan during a policy year to any one individual exceed a specified individual trigger amount, which is set in the policy. Under an aggregate stop-loss provision, The Travelers provides coverage only if the aggregate benefits paid during the policy year exceed an aggregate trigger amount, which is set in the policy. Some of the stop-loss policies issued by The Travelers contain both individual and aggregate stop-loss provisions.

16. Under a stop-loss policy, until the amount of benefits paid by the plan exceeds the applicable trigger amount, The Travelers has no obligation to make payments to either the employer or the employees. If and when the benefits exceed the applicable trigger amount, The Travelers is obligated under the policy to reimburse the employer for the amount of payments above the trigger amount. However, unlike a group insurance policy, The Travelers has no obligation to the employees or their dependents. In many instances, the stop-loss programs administered by The Travelers operate for years without paying benefits over the applicable trigger amount.

17. B.H. Aircraft Company, Inc. ("B.H. Aircraft") is a New York corporation with its principal place of business in Farmingdale, New York. B.H. Aircraft is in the business of

manufacturing aircraft parts, and conducts its operations in New York.

18. B.H. Aircraft provides group accident and health insurance to 122 employees under a plan which is subject to ERISA (the "B.H. Plan"). The Travelers has issued a policy to B.H. Aircraft which provides accident and health insurance to B.H. Aircraft's employees and their dependents (the "B.H. Policy"). The B.H. Plan and the B.H. Policy provide coverage to 121 employees of B.H. Aircraft in New York and one employee in Connecticut. The Travelers pays claims made by employees of B.H. Aircraft and their dependents. With regard to the adjudication of such claims, The Travelers is a fiduciary of the B.H. Plan within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

19. The B.H. Policy includes coverage for the amount charged to an employee for inpatient hospital care. The Travelers sets the premium for the B.H. Policy once a year to reflect the cost of providing coverage, including the cost of inpatient hospital coverage. The B.H. Policy is typical of the group health insurance policies which The Travelers issues to employers in the State of New York.

20. Sheridan Catheter Corporation ("Sheridan Catheter") is a New York corporation with its principal place of business in Argyle, New York. Sheridan Catheter is in the business of producing medical equipment and supplies, and conducts its operations in New York, but with sales staff in the following additional states: California, Georgia, Illinois, Maryland, Missouri, Ohio, Pennsylvania, Tennessee, Texas and Washington.

21. Sheridan Catheter provides group accident and health benefits to 242 employees under a plan which is subject to the terms of ERISA (the "Sheridan Catheter Plan"). The Sheridan Catheter Plan is self-insured. The Sheridan Catheter Plan provides coverage to 232 employees of Sheridan Catheter in New

York, and 10 employees in the other states listed in paragraph 20. The Sheridan Catheter Plan provides coverage to Sheridan Catheter's employees for inpatient hospital care. Claims are administered pursuant to an administrative services only agreement with The Travelers (the "Sheridan Catheter Contract"). With regard to the administration of such claims, The Travelers is a fiduciary of the Sheridan Catheter Plan within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

22. In addition, Sheridan Catheter has purchased a stop-loss policy from The Travelers which provides both individual and aggregate stop-loss coverage (the "Sheridan Catheter Policy"). Under the aggregate stop-loss provision of the Sheridan Catheter Policy, The Travelers provides coverage only if the aggregate benefits paid by Sheridan Catheter during the applicable contract period exceed 125% of annual anticipated health care claims. Under the individual stop-loss provision of the Sheridan Catheter Policy, The Travelers provides coverage only if benefits paid by Sheridan Catheter during the applicable policy period for any one employee or dependent exceed $90,000. Until the benefits paid by Sheridan Catheter exceed the individual or aggregate trigger amount, The Travelers administers claims on Sheridan Catheter's behalf using funds provided by Sheridan Catheter. If the benefits paid by Sheridan Catheter exceed the individual or aggregate trigger amount, under the terms of the Sheridan Catheter Policy, The Travelers reimburses Sheridan Catheter for the amount of payments above the applicable trigger amount. Unlike a group insurance policy, The Travelers has no obligation to pay benefits to Sheridan Catheter employees under the Sheridan Catheter Policy.

23. The Sheridan Catheter Policy is typical of the stop-loss policies issued by The Travelers in order to provide excess risk insurance to self-insured plans. An employer's purchase of excess risk insurance to protect against catastrophic loss does not alter the fact that the plan is essentially self-insured.

COUNT I

(CLAIM FOR DECLARATION THAT ERISA PREEMPTS THE SUPPLEMENTAL 11% SURCHARGE)

24. The Travelers repeats and realleges paragraphs 1 through 23 of this complaint as if fully set forth herein.

25. Under Section 2807-c of the New York Public Health Law, the rate of payment to general hospitals for inpatient hospital care in New York is regulated. Except in cases such as that of an uninsured person, the rates for inpatient hospital care are generally set on the basis of categories relating to the diagnosis of illness, known as Diagnosis Related Groups or DRG's. Under this system, the amount charged for inpatient hospital care is set on the basis of the DRG into which the patient falls, rather than the actual cost of the treatment. In addition, as described below, the DRG amount is multiplied by a "payor factor" which creates a differential among the amounts charged to various payors such as a self-insured plan, health maintenance organization, The Travelers or a Blue Cross company.

26. Under Section 2807-c(1)(a), the rate of general hospital inpatient reimbursement for patients eligible for payments made by state governmental agencies or pursuant to a Blue Cross plan is the applicable DRG rate.

27. Under Section 2807-c(1)(b), the rate of general hospital inpatient reimbursement for patients "enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis" is 113% of the applicable DRG rate.

28. Prior to April 1, 1992, under Section 2807-c(1)(b), the rate of general hospital inpatient reimbursement for a person "insured under a commercial insurer licensed to do business in [New York]

and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, and the insurer makes payments directly to the general hospital" was 113% of the applicable DRG rate.

29. Prior to April 1, 1992, the revenue raised under Section 2807-c(1)(b) was available to the hospital providing the service to offset the cost of providing health care.

30. On April 2, 1992, the New York Legislature passed the Omnibus Tax Revenue Act of 1992 ("the Act"). As relevant to the allegations herein, the Act became effective immediately. Section 348 of the Act imposes an additional surcharge of 11% on the DRG rates paid by commercial insurance companies under section 2807-c(1)(b) for inpatient hospital care. This additional 11% is not available to hospitals to cover the cost of providing medical care. Instead, Section 349 of the Act requires that the 11% surcharge be paid by or on behalf of the collecting hospitals into a statewide pool maintained by the Commissioner of Health, who, in turn, pays these monies into the New York State General Fund.

31. Specifically, Section 348 of the Act provides, in pertinent part, as follows:

> Paragraph (i) of subdivision 11 of section 2807-c of the public health law is REPEALED and a new paragraph (i) is added to read as follows:
>
> (i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an

expense incurred basis, the payment rate shall be increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent.

32. Section 349 of the Act provides, in pertinent part, as follows:

Section 2807-c of the public health law is amended by adding a new subdivision 14-e to read as follows:

14-e. Supplementary payment rate conversion factor statewide pool. (a) Funds will be accumulated in a statewide pool created by the commissioner [of Health] through the submissions by or on behalf of general hospitals of the component of rates of payment reflecting the supplementary payment rate conversion factor provided in accordance with paragraph (i) of subdivision eleven of this section.

(b) Funds accumulated in the supplementary payment rate conversion factor statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

33. Because Section 348 of the Act is void and unenforceable for the reasons described below, The Travelers is not paying the supplemental 11% surcharge for inpatient hospital care rendered to a person insured by The Travelers in connection with an ERISA plan. Instead, in each such case, The Travelers is segregating the amount due for the supplemental 11% surcharge.

The Travelers will pay all amounts due if this Court finds that Section 348 of the Act is enforceable. The Travelers is continuing to pay the 13% surcharge.

34. ERISA was enacted by Congress for the purpose, among others, of regulating employee welfare benefit plans through a uniform, nationwide, regulatory scheme governing such plans.

35. Section 514(a) of ERISA, 29 U.S.C. §1144(a), provides, in pertinent part, that ERISA:

> shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title [29 U.S.C. §1003(a)] . . . .

36. Section 348 of the Act imposes a supplemental 11% surcharge on plans such as the B.H. Plan which provide coverage for inpatient hospital care to employees through an insurance policy issued by a commercial insurer such as The Travelers.

37. Under Section 349 of the Act, the 11% supplemental surcharge ultimately is paid into the New York State General Fund. The hospital providing the service does not retain any of the revenue raised as a result of the supplemental 11% surcharge.

38. The supplemental 11% surcharge has a substantial effect on the operation of an ERISA plan such as the B.H. Plan. When coupled with the 13% surcharge provided for in Section 2807-c(1)(b), the supplemental 11% surcharge imposes a substantial penalty on any ERISA plan which chooses to obtain coverage for inpatient hospital care from a commercial insurer such as The Travelers rather than from a Blue Cross company.

39. The supplemental 11% surcharge also places The Travelers at a significant disadvantage with regard to the marketing and sale of group health insurance.

40. Section 348 of the Act relates to an employee benefit plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

41. Section 348 of the Act is preempted by ERISA and should be declared null and void and unenforceable by defendants.

42. Section 348 of the Act is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

COUNT II

(CLAIM FOR DECLARATION THAT SECTION 348 OF THE ACT DOES NOT APPLY TO PAYMENTS MADE BY SELF-INSURED PLANS)

43. The Travelers repeats and realleges paragraphs 1 through 42 of this complaint as if fully set forth herein.

44. Defendant McBarnette takes the position that Section 348 of the Act applies to self-insured plans with stop-loss coverage purchased by employers from a commercial insurer such as The Travelers.

45. This interpretation is contrary to the plain language of Section 348 of the Act which provides that the supplemental 11% surcharge only applies in the case of a patient "insured" by a "commercial insurer . . . whose policy provides inpatient hospital coverage on an expense incurred basis." Unlike the existing 13% surcharge under Section 2807-c(1)(b), which clearly applies in the case of patients "enrolled in a self-insured

fund," Section 348 of the Act makes no reference to persons covered by a self-insured plan.

46. The Sheridan Catheter Plan is self-insured. Until the benefits paid in any one-year period by Sheridan Catheter exceed the individual or aggregate trigger amount, Sheridan Catheter pays all claims. Even after the trigger amount has been exceeded, employees and dependents under the Sheridan Catheter plan are not "insured" by a "commercial insurer . . . whose policy provides inpatient hospital coverage on an expense incurred basis." Under the terms of the Sheridan Catheter Policy, The Travelers does not insure the employee and his dependents or pay for inpatient hospital care. Instead, The Travelers reimburses Sheridan Catheter for the amount of payments in excess of the individual or aggregate trigger amount. Such reimbursement is not insuring a patient for inpatient hospital coverage under Section 2807-c(1)(b).

47. The stop-loss policies issued by The Travelers in connection with other self-insured plans are similar to the Sheridan Catheter Policy. Each policy providing aggregate stop-loss coverage provides reimbursement to the employer only after the employer has paid claims of a substantial amount, equal to at least 100% of the employer's annual anticipated health care claims. This means that unless the self-insured employer's total actual annual health care claims exceed the total anticipated claims, there is no insurance coverage provided under the aggregate stop-loss provision of the policy. Even when the aggregate trigger amount has been exceeded, The Travelers does not provide insurance benefits to the employee or his dependents. Instead, The Travelers reimburses the employer for the gross amount of claims in excess of the trigger amount. The same is true with regard to the individual stop-loss provisions of the stop-loss policies issued by The Travelers.

48. Defendants' interpretation of Section 348 imposes a substantial penalty on self-insured plans with stop-loss coverage such as the Sheridan Catheter Plan, and drives up the costs of providing benefits to persons covered under such plans.

49. Defendants' interpretation of Section 348 also has a substantial impact on the business of The Travelers. Imposition of the supplemental surcharge to such claims increases the overall cost to the plan of the claims administered by The Travelers.

50. Accordingly, plaintiff The Travelers is entitled to a declaration that the supplemental 11% surcharge does not apply in the case of any patient covered by the Sheridan Catheter Plan or any other self-insured plan with stop-loss coverage provided by The Travelers.

COUNT III

(ALTERNATIVE CLAIM FOR DECLARATION THAT ERISA PREEMPTS THE SUPPLEMENTAL 11% SURCHARGE)

51. The Travelers repeats and realleges paragraphs 1 through 50 of this complaint as if fully set forth herein.

52. If this Court concludes that Section 348 of the Act applies to self-insured ERISA plans with stop-loss coverage, the supplemental 11% surcharge will have a substantial effect on the operation of self-insured ERISA plans such as the Sheridan Catheter Plan.

53. When coupled with the 13% surcharge provided for in Section 2807-c(1)(b), the supplemental 11% surcharge imposes a substantial penalty on any ERISA plan which chooses to provide coverage to participants on a self-insured basis with stop-loss coverage rather than obtaining coverage from a Blue Cross company.

54. If interpreted to apply to a self-insured ERISA plan with stop-loss coverage, Section 348 of the Act relates to an employee welfare benefit plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

55. If interpreted to apply to a self-insured ERISA plan with stop-loss coverage, Section 348 of the Act is preempted by ERISA and should be declared null and void and unenforceable by defendants.

56. If interpreted to apply to a self-insured ERISA plan with stop-loss coverage, Section 348 of the Act is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

COUNT IV

(CLAIM FOR DECLARATION THAT ERISA PREEMPTS THE 13% SURCHARGE)

57. The Travelers repeats and realleges paragraphs 1 through 56 of this complaint as if fully set forth herein.

58. Section 2807-c(1)(b) imposes a 13% surcharge for inpatient hospital care rendered to persons covered by either a self-insured ERISA plan such as the Sheridan Catheter Plan or an ERISA plan with insurance provided by a commercial insurer such as the B.H. Plan.

59. Section 2807-c(1)(b) imposes a 13% surcharge on those employers who decide to provide coverage to their employees under a self-insured plan or pursuant to a policy of insurance obtained from a commercial insurer, rather than obtaining coverage from a Blue Cross company. This additional 13% surcharge has a substantial impact on the ability of an employer to provide coverage for inpatient hospital care to its employees.

60. The 13% surcharge also has a substantial impact on the business of The Travelers. In the case of an insured plan such as the B.H. Plan, the 13% surcharge causes The Travelers to increase the premium it charges for a group policy. In the case of a self-insured plan such as the Sheridan Catheter Plan, the 13% surcharge increases the overall cost to the plan of the claims administered by The Travelers. In each case, the 13% surcharge interferes with The Travelers ability to sell its services on a competitive basis.

61. Section 2807-c(1)(b) relates to an employee welfare benefit plan, within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

62. Section 2807-c(1)(b) is preempted by ERISA and should be declared null and void and unenforceable by defendants.

63. Section 2807-c(1)(b) is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

COUNT V

(CLAIM FOR DECLARATION THAT THE ACTUARIAL LETTER IS UNENFORCEABLE)

64. The Travelers repeats and realleges paragraphs 1 through 23, 34 and 35 of this complaint as if fully set forth herein.

65. Actuarial Information Letter Number Five (the "Actuarial Letter") issued by defendant Curiale sets forth substantive and procedural requirements which must be satisfied before the Department of Insurance will approve the form of a stop-loss policy such as the Sheridan Catheter Policy.

66. Sections 3216 and 3221 of The New York Insurance Law require that insurers issuing accident and health insurance

policies include certain statutorily mandated benefits. Section 3221 of the New York Insurance Law also mandates conversion privileges for group or blanket accident and health insurance policies. These laws apply to insurers, and not to self-insured plans.

67. The Actuarial Letter requires, as a condition for the approval of a stop-loss policy, that the policy or an undertaking signed by the insurer provide (1) that the insurer undertake to ensure that the employee benefit plan covered by the policy provide statutorily mandated benefits, (2) that the insurer undertake to ensure that statutorily mandated conversion policies be provided, (3) that notice be given to employees when the insurer becomes liable for run-off claims, and (4) that the insurer take primary responsibility for the payment of employee benefit plan claims incurred but unpaid at the policy termination date (unless certain conditions are met). Thus, the Actuarial Letter requires that a self-insured ERISA plan provide its employees with certain mandated benefits and guarantees if the plan obtains any form of stop-loss coverage.

68. The Actuarial Letter establishes substantive and procedural requirements which clearly are intended to govern the terms of self-insured group health plans. Accordingly, in order to be enforceable, the provisions of the Actuarial Letter would have to be promulgated as a rule in accordance with the provisions of the New York State Administrative Procedure Act ("NYSAPA"). Sections 202 and 202-a of the NYSAPA require public notice of a proposed regulation, "an opportunity to be heard" and the filing of a regulatory impact statement. In addition, under Section 203 of the NYSAPA and Section 102 of the New York Executive Law, prior to becoming effective, a proposed regulation must be filed by the Insurance Department with the Secretary of State who shall compile the regulation and publish it in the "official compilation of codes, rules and regulations of the state of New York."

69. Defendant Curiale has not promulgated the provisions of the Actuarial Letter as a rule in accordance with the above provisions of the NYSAPA and the Executive Law.

70. Accordingly, the Actuarial Letter is not enforceable with regard to any stop-loss policy issued by The Travelers.

COUNT VI

(ALTERNATIVE CLAIM THAT ERISA PREEMPTS THE ACTUARIAL LETTER)

71. The Travelers repeats and realleges paragraphs 1 through 23, 34, 35, and 65 through 70 of this complaint as if fully set forth herein.

72. If this Court concludes that the Actuarial Letter is enforceable against The Travelers under New York law, then this Court should rule that ERISA preempts the application of the Actuarial Letter to any stop-loss policy issued by The Travelers in connection with a self-insured ERISA plan.

73. The Actuarial Letter requires that a self-insured ERISA plan provide the benefits and guarantees set forth in the Actuarial Letter in order to obtain stop-loss coverage. Accordingly, if enforceable, the Actuarial Letter relates to an employee benefit plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

74. If enforceable, the Actuarial Letter is preempted by ERISA and should be declared null and void and unenforceable by defendants.

75. If enforceable, the Actuarial Letter is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

WHEREFORE, plaintiff The Travelers demands judgment:

(a) declaring and determining that ERISA preempts the application of the supplemental 11% surcharge of Section 348 of the Act in the case of any person participating in an ERISA plan, and enjoining defendants from enforcing the 11% supplemental surcharge in such cases;

(b) declaring and determining that the 11% supplemental surcharge of Section 348 of the Act does not apply to a person covered under a self-insured plan with stop-loss coverage, and enjoining defendants from enforcing the 11% supplemental surcharge in such cases;

(c) declaring and determining that ERISA preempts the application of the 13% surcharge of New York Public Health Law Section 2807-c(1)(b) in the case of any person participating in an ERISA plan, and enjoining defendants from enforcing the 13% surcharge in such cases;

(d) declaring and determining that the Actuarial Letter is not enforceable, and enjoining defendants from enforcing it;

(e) declaring and determining that ERISA preempts the enforcement of the Actuarial Letter with regard to any stop-loss policy issued in connection with an ERISA plan, and enjoining the defendants from enforcing the Actuarial Letter in such cases; and

(f) awarding plaintiff The Travelers the costs incurred in prosecuting this action, including reasonable attorneys' fees.

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, AND PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs,

-against-

MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, MARY JO BANE in her Official Capacity as Commissioner of Social Services of the State of New York, SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York, and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York,

Defendants.

Case No. 92 Civ. 5419 (LJF)

Amended Complaint, filed August 10, 1992

Plaintiffs, by their undersigned attorneys, for their complaint, allege:

NATURE OF THE ACTION

1. This action seeks to invalidate certain laws of the State of New York on the ground that they are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which (with exceptions not applicable here) expressly supersedes all state laws and regulations "insofar as they . . . relate to any employee benefit plan" covered by ERISA.

2. Under the recently enacted Omnibus Revenue Act of 1992 ("the Act"), New York requires hospitals to impose an 11% surcharge on bills to patients covered by commercial health insurance and to pay over this 11% surcharge to the State of New York for inclusion in its general revenues. The 11% surcharge is imposed *only* to the extent that patients are covered by commercial health insurance. The surcharge, thus, does not apply at all to bills for patients who are covered by Blue Cross, who belong to health maintenance organizations ("HMOs"), who are self-insured, or who have no insurance.

3. Moreover, this 11% surcharge is added to a previously enacted 13% surcharge imposed by section 2807-c(1)(b) of New York's Public Health Law ("the Statute"), on hospital bills to virtually all patients with any form of health coverage other than a Blue Cross plan, an HMO, or a government plan such as Medicare. The funds from the 13% surcharge are retained by the hospital for its own use.

4. Finally, the Act, in certain circumstances, imposes a surcharge of up to 9% that applies only to bills for inpatient hospital care to persons who belong to HMOs.

5. In New York, the vast majority of persons covered by commercial health insurance and self-insured plans, and a substantial number of the persons subscribing to HMOs, receive

that coverage pursuant to employee benefit plans subject to ERISA. The primary effect of these surcharges, therefore, is to increase the cost of benefits paid out by ERISA employee benefit plans that use any of these methods to provide health coverage for their participants and beneficiaries. Moreover, these surcharges create differentials between the cost of benefits to ERISA employee benefit plans, depending on the method used by the plan to provide health benefits. For example, the bills for hospital care under an ERISA employee benefit plan covered by commercial health insurance are 24% more than if the plan were covered by Blue Cross and 11% more than if the plan were self-insured.

6. The inevitable effect of these surcharges is to increase the cost of commercially-insured and self-insured employee benefit plans, reduce the coverage provided by such employee benefit plans, or force employers and plan administrators to choose other means for funding employee benefit plans. In certain circumstances, the surcharges will have similar effects on ERISA employee benefit plans that utilize HMOs. These surcharges therefore will force employers or plan administrators to tailor their ERISA employee benefit plans to the peculiarities of New York law.

7. In sum, the New York laws imposing these surcharges have direct, profound and detrimental effects upon ERISA employee benefit plans. They are, therefore, laws that "relate to" employee benefit plans, and are superseded by ERISA and rendered invalid under the Supremacy Clause of the United States Constitution.

JURISDICTION AND VENUE

8. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 in that the dispute arises under the Supremacy Clause of the Constitution of the United States, and the suit is also brought

pursuant to 29 U.S.C. § 1132(a)(3). Plaintiffs seek declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202.

9. Venue is proper pursuant to 28 U.S.C. § 1391(b) and 29 U.S.C. 1132(e)(2) in that defendants Salvatore R. Curiale and Robert Abrams reside in the Southern District of New York, a substantial part of the events giving rise to the claim have occurred and continue to occur in the Southern District of New York, and many of the employee benefit plans that are the subject of this lawsuit are administered there.

THE PARTIES

10. Plaintiff Health Insurance Association of America ("HIAA") is a trade association organized to promote and protect the interests of its members, which are commercial writers of health insurance throughout the United States. It represents the interests of approximately 300 member companies that provide health coverage to over 90 million people in the United States. On information and belief, HIAA's members also issue the great majority of the commercial group health insurance policies in the State of New York. The vast majority of these policies and the group health insurance policies issued by members of the other trade association plaintiffs in New York are purchased pursuant to employee benefit plans as defined by ERISA ("employee benefit plans"). Many of the employee benefit plans that purchase commercial health insurance from members of HIAA (and from the other plaintiffs) to cover employees in New York also cover employees in other states. HIAA is itself the fiduciary for an employee benefit plan that provides commercially-insured health and hospital coverage to former HIAA employees residing in New York.

11. Many of HIAA's members also serve as claims administrators and claims fiduciaries for self-insured ERISA

plans that provide inpatient hospital coverage in New York (hereafter referred to as the "self-insured plans").

12. Some of HIAA's members also own, in whole or in part, HMOs organized pursuant to Article 44 of New York's Public Health Law. Such HMOs provide full health coverage, including coverage of inpatient hospital care, to subscribers, many of whom are enrolled pursuant to employee benefit plans.

13. The amount of dues HIAA assesses on its members is primarily determined by the total insurance premiums and the amount of claims its members process in administering self-insured plans. HIAA brings this suit on behalf of its members as well as on its own behalf.

14. Plaintiff American Council of Life Insurance ("ACLI") is a trade association representing 611 companies, of which 125 are licensed to do business in New York. ACLI's members write approximately 95% of the life insurance and about 80% of the health insurance policies currently purchased in the United States and in the State of New York. On information and belief, ACLI's members, many of which also belong to HIAA, issue the vast majority of the commercially-insured group health insurance policies in the State of New York. The vast majority of those policies are issued pursuant to employee benefit plans as defined by ERISA. Some of ACLI's members serve as claims administrators and claims fiduciaries for certain self-insured plans in the State. ACLI itself is the fiduciary for an employee benefit plan that provides commercially insured health and hospital coverage to ACLI's employees and to certain HIAA employees in New York. Some of ACLI's members also own, in whole or in part, HMOs which enroll a large number of subscribers pursuant to employee benefit plans. The amount of dues ACLI assesses on its members is primarily determined by the total premiums its members receive. ACLI brings this suit on behalf of its members as well as on its own behalf.

15. Plaintiff Life Insurance Council of New York, Inc. ("LICONY") is a trade association with 64 members organized to promote and protect the interests of its members—commercial writers of life insurance in the State of New York—some of which write health insurance policies. On information and belief, LICONY's members—most of which also belong to HIAA or ACLI—write a significant percentage of the commercial health insurance policies in New York State, most of which are purchased pursuant to employee benefit plans. In addition, LICONY's members serve as claims administrators and claims fiduciaries for self-insured plans in New York. Two of LICONY's members own, in whole or in part, HMOs which enroll a large number of subscribers pursuant to employee benefit plans. LICONY is itself the fiduciary for an employee benefit plan that provides commercially-insured health and hospital coverage to LICONY's employees in New York. The amount of dues LICONY assesses on its members is determined by the total premiums its members receive and its members' assets. LICONY brings this suit on behalf of its members as well as on its own behalf.

16. Plaintiff Aetna Life Insurance Company ("Aetna Life") is a commercial insurance company authorized to do business in New York, and in all of the fifty states. Aetna Life issues commercial health and hospital insurance coverage to employee benefit plans with participants in New York and is the claims fiduciary for such plans. Aetna Life also administers self-insured plans in New York and serves as claims fiduciary for many such plans.

17. Plaintiff Aetna Health Plans of New York, Inc. ("Aetna Health Plans") is an HMO licensed in the State of New York that provides health coverage, including hospital coverage, to its enrollees. Enrollment in Aetna Health Plans is offered as an option to participants in the employee benefit plans covering employees of Aetna Life and Aetna Health Plans in New York

and to participants in other employee benefit plans in the State. Aetna Health Plans serves as fiduciary for claims filed by its enrollees.

18. Plaintiff Mutual of Omaha Insurance Company ("Mutual of Omaha") is a mutual insurance company authorized to do business in the State of New York and in all of the fifty states. Mutual of Omaha issues commercial health and hospital insurance coverage for employee benefit plans and is a claims fiduciary for those plans. Mutual of Omaha is itself the fiduciary for a self-insured employee benefit plan that provides health and hospital coverage to employees of Mutual of Omaha and its subsidiaries and affiliates residing in New York.

19. Plaintiff The Union Labor Life Insurance Company ("Union Labor") is a commercial insurance company licensed to do business in New York and in all fifty states. Union Labor issues commercial health and hospital insurance coverage to employee benefit plans in New York State. Union Labor is also an administrator for certain self-insured plans in New York. Union Labor is itself the fiduciary for a commercially-insured employee benefit plan that provides health and hospital coverage to employees of Union Labor and its affiliates residing in New York.

20. Plaintiff Professional Insurance Agents of New York, Inc. Trust ("PIA Trust") is the fiduciary for a commercially-insured employee benefit plan that provides benefits, including health and hospital coverage, to members of the Professional Insurance Agents of New York State, Inc. and to similar groups in two other states.

21. Defendant Mark Chassin, M.D. is the Commissioner of Health of the State of New York. The Department of Health of the State of New York (the "Department of Health") is charged with administering the 13% surcharge imposed by the Statute and the

11% surcharge imposed by the Act. Defendant Chassin maintains an office at Nelson Rockefeller Empire State Plaza, Corning Tower Building, Albany, New York 12237.

22. Defendant Mary Jo Bane is the Commissioner of Social Services of the State of New York, and is charged with administering the surcharges on HMOs imposed by the Act. Defendant Bane maintains an office at 40 North Pearl Street, Albany, New York 12243.

23. Defendant Salvatore R. Curiale is the Superintendent of Insurance of the State of New York. Pursuant to Section 335 of the Insurance Law of the State of New York, defendant Curiale is empowered to prescribe and enforce rules and regulations governing insurance procedures that relate to the implementation of the hospital reimbursement provisions of the Public Health Law, including reimbursements giving rise to surcharges at issue in this litigation. Defendant Curiale maintains an office at 160 West Broadway, New York, New York 10013 which is his official residence.

24. Defendant Robert Abrams is the Attorney General of the State of New York, and is charged with enforcing compliance with the State's laws and regulations, including those at issue in this litigation, under New York Executive Law § 63(1) and (12). The Attorney General maintains an office at 120 Broadway, New York, New York 10271 which is his official residence.

NEW YORK'S SURCHARGES ON HOSPITAL BILLS FOR PATIENTS COVERED BY COMMERCIAL INSURANCE AND SELF-INSURED PLANS

25. Under New York's Public Health Law, the State, with certain exceptions, requires hospitals to charge standardized payment rates for inpatient care. Public Health Law § 2807-c(1). Under this system, medical procedures are divided into categories

based on the patient's diagnosis, known as Diagnosis Related Groups ("DRG"s). Public Health Law § 2807-c(1)(A). Hospitals are required by law to charge, and payors are required to pay, the DRG rate applicable to an insured patient's diagnosis, as adjusted by a formula reflecting costs specific to each individual hospital. The actual amount charged for inpatient hospital care varies, however, depending on whether the individual patient is covered by a health plan and the type of such plan.

26. Under Section 2807-c(1)(b) of the Public Health Law, the DRG rate is increased by a 13% surcharge ("the 13% Surcharge") imposed on payments for inpatient services to virtually all patients covered by any form of health plan (including commercially insured and self-insured employee benefit plans), except for patients covered by Blue Cross, an HMO, or government plans like Medicare. The funds generated by this 13% surcharge are retained by the hospital.

27. Section 348 of the Omnibus Revenue Act of 1992, adopted on April 2, 1992, amends New York's Public Health Law to impose an additional eleven percent (11%) surcharge (the "11% Surcharge") on DRG payment rates charged by hospitals *only* to patients insured by commercial insurers. Section 348 of the Act provides in relevant part:

> Paragraph (i) of subdivision 11 of section 2807-c of the public health law is REPEALED and a new paragraph (i) is added to read as follows:
>
> (i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, the payment rate shall be

> increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent. . . .

28. The Act requires hospitals to submit the funds raised by the 11% Surcharge to a pool established by the Commissioner of Health, who, in turn, must deposit those funds into the State's general fund. Thus, Section 349 provides:

> Section 2807-c of the public health law is amended by adding a new subdivision 14-e to read as follows:
>
> 14-e. Supplementary payment rate conversion factor statewide pool. (a) Funds will be accumulated in a statewide pool created by the commissioner through the submissions by or on behalf of general hospitals of the component of rates of payment reflecting the supplementary payment rate conversion factor provided in accordance with paragraph (i) of subdivision eleven of this section.
>
> (b) Funds accumulated in the supplementary payment rate conversion factor statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

29. Inasmuch as commercial health insurance plans usually do not cover 100% of the DRG rate (because of coinsurance, deductibles or other policy limitations), the Department of Health has interpreted the 11% Surcharge to apply only to that portion of the hospital charges reimbursable under commercial health insurance. Hence, in the case of employee benefit plans covered by commercial health insurance, the 11% Surcharge is imposed only on the hospital charges covered by the employee benefit plan.

NEW YORK'S SURCHARGES ON HOSPITAL BILLS FOR PATIENTS ENROLLED IN HMOs

30. Section 346 of the Act, effective as of July 1, 1992, sets forth several methods for determining the standardized rate applicable to inpatient care rendered to HMO subscribers, ranging from the DRG rate to standardized rates negotiated by the particular HMO.

31. Section 346 of the Act amends New York's Public Health Law to impose a surcharge of up to nine percent (9%) on the applicable rates hospitals charge for inpatient care to HMO subscribers (the "HMO Surcharge"). Section 346 of the Act provides that the HMO Surcharge may be reduced by up to seven percent (7%) for HMOs that provide certain services or achieve certain goals. The Act also provides for elimination of all or part of the HMO Surcharge in certain circumstances.

32. Pursuant to Section 346, beginning on July 1, 1992, each HMO must pay the amount it owes each month for the HMO Surcharge directly into a statewide pool to be established by the Commissioner of Social Services of the State of New York, for deposit into the State's general fund.

THE IMPACT OF THE NEW YORK SURCHARGES

Employee Benefit Plans Covered by Commercial Health Insurance

33. Inasmuch as the vast majority of commercial health insurance contracts in New York State are written to cover employee benefit plans, the primary effect of the 11% and 13% Surcharges is to raise the cost of benefit plans covered by commercial health insurance.

34. The surcharges force employee benefit plans covered by commercial health insurance to pay out benefits that are 24% higher for the same services than would be paid if such plans were covered by Blue Cross, 11% higher than if such plans were self-insured, and at least 15% to 24% higher than if such plans provided health coverage through an HMO.

35. Inasmuch as the premiums for commercial health insurance reflect the cost of claims for hospital services, the 11% and 13% Surcharges increase the premiums charged by commercial health insurers to employee benefit plans covered by commercial insurance.

36. As a result of the 11% and 13% Surcharges, administrators and fiduciaries of employee benefit plans covered by commercial health insurance, including plaintiff trade associations, Union Labor and PIA Trust, are forced to accept higher premiums or reduced benefit coverage, or choose some other method for providing coverage under the plan that is not subject to the 11% or 13% Surcharge. The 11% and 13% Surcharges thus force administrators or fiduciaries of employee benefit plans covered by commercial health insurance to tailor their ERISA plans to the peculiarities of New York law.

37. As a result, commercial insurers, including the members of the plaintiff trade associations, are likely to lose business and the plaintiff trade associations are threatened with a loss of dues.

Self-Insured Employee Benefit Plans

38. Inasmuch as the vast majority of self-insured plans in New York are employee benefit plans, the 13% Surcharge directly raises the cost of employee benefit plans that are self-insured.

39. The 13% Surcharge forces employee benefit plans that are self-insured, including the plan operated by plaintiff Mutual of

Omaha, to pay out benefits that are 13% higher for the same services than would be paid out if the plans were covered by Blue Cross and at least 4% to 13% higher than if the plans subscribed to an HMO.

40. As a result of the 13% Surcharge, self-insured employee benefit plans, including Mutual of Omaha, are forced to accept higher costs, or reduce benefit coverage, or choose some other method of providing coverage under the plan that is not subject to the 13% Surcharge. The 13% Surcharge thus forces administrators or fiduciaries of employee benefit plans that are self-insured to tailor their ERISA plans to the peculiarities of New York law.

41. As a result, commercial insurers are threatened with loss of the income they receive from administering self-insured plans. The trade association plaintiffs are threatened with a further loss of dues.

Employee Benefit Plans Utilizing HMOs

42. In certain circumstances, the HMO Surcharge raises the cost of providing health coverage through an HMO by as much as 9%. The HMO Surcharge thus directly increases the cost of providing hospital care to certain HMO subscribers enrolled pursuant to employee benefit plans.

43. As a result of the HMO Surcharge, administrators of employee benefit plans providing health care in whole or in part through an HMO (including plans covering employees of plaintiffs Aetna Life and Aetna Health Plans) will, in certain circumstances, be forced to pay more for HMO coverage, accept reduced HMO benefits, or choose Blue Cross—which is exempt from all of the surcharges—as a method for providing coverage under such plans. The HMO Surcharge therefore forces administrators or fiduciaries of employee benefit plans providing

health and hospital coverage through an HMO, including plans covering employees of Aetna Life and Aetna Health Plans, to tailor their ERISA plans to the pecularities of New York law.

44. As a result, members of plaintiff trade associations that own all or part of an HMO, including plaintiff Aetna Health Plans, will lose HMO business.

COUNT ONE
(ERISA PREEMPTS THE 11% SURCHARGE)

45. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 44 above.

46. Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." Section 514(c)(1) of ERISA, 29 U.S.C. § 1144(c)(1), provides that "[t]he term 'State Law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."

47. Section 348 of the Act, which imposes the 11% Surcharge, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

48. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, Section 348 of the Act, insofar as it imposes the 11% Surcharge on the payment rate for hospital care to patients covered by an employee benefit plan, is preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

49. Plaintiffs are threatened with imminent irreparable injury.

50. Plaintiffs have no adequate remedy at law.

COUNT TWO
(ERISA PREEMPTS THE 13% SURCHARGE)

51. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 50 above.

52. Section 2807-c(1)(b) of the Statute, which imposes the 13% Surcharge, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

53. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, Section 2807-c(1)(b) of the Statute, insofar as it imposes the 13% Surcharge on the payment rate for hospital care to patients covered by an employee benefit plan, is preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

54. Plaintiffs are threatened with imminent irreparable harm.

55. Plaintiffs have no adequate remedy at law.

COUNT THREE
(ERISA PREEMPTS THE HMO SURCHARGE)

56. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 55 above.

57. Section 346 of the Act, which imposes the HMO Surcharge, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

58. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, Section 346 of the Act, insofar as it imposes surcharges on payment rates for hospital care to patients covered by an employee benefit plan, is

preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

59. Plaintiffs are threatened with imminent irreparable harm.

60. Plaintiffs have no adequate remedy at law.

COUNT FOUR
(PREEMPTION UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT)

61. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 60 above.

62. Plaintiff Mutual of Omaha also issues commercial insurance policies that provide health and hospital coverage to federal employees pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. 8901, *et seq.*

63. Under FEHBA, an employee health benefits fund is established in the United States Treasury, administered by the Office of Personnel Management (the "Fund"). This Fund is used to pay approved health benefits, administration expenses and insurance premiums.

64. Thus, under FEHBA, premiums paid to plaintiff Mutual of Omaha are used to pay health and hospital charges incurred by federal employees and come out of the Fund. The 11% and 13% Surcharges therefore will necessarily increase the payments made from the Fund to Mutual of Omaha for health and hospital coverage for federal employees.

65. FEHBA, 5 U.S.C. § 8909(f)(1), provides:

> no tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or underwriting or plan

> administration subcontractor of an approved health benefits plan by any State . . . with respect to any payment made from the Fund.

66. To the extent they apply to payments made by the Fund to Mutual of Omaha pursuant to FEHBA plans underwritten by Mutual of Omaha, the 11% and 13% Surcharges constitute a monetary payment imposed by the State of New York on Mutual of Omaha as a carrier or underwriting subcontractor of an improved FEHBA health benefits plan.

67. Accordingly, insofar as Section 348 of the Act and Section 2807-C(1)(b) of the Statute apply surcharges to the payment rate for hospital care to patients covered by FEHBA plans, they are preempted under the Supremacy Clause of the Constitution of the United States and are invalid.

68. Plaintiff Mutual of Omaha is threatened with imminent irreparable injury.

69. Plaintiff Mutual of Omaha has no adequate remedy at law.

WHEREFORE, plaintiffs ask this Court for a judgment:

> (i) declaring that ERISA preempts Section 348 of the Act and renders it unenforceable insofar as it imposes the 11% Surcharge on hospital bills for inpatient care provided to any participant in, or beneficiary of, an ERISA employee benefit plan;
>
> (ii) declaring that ERISA preempts Section 2807-(c)(1)(b) of New York's Public Health Law and renders it unenforceable insofar as it imposes the 13% Surcharge on hospital bills for inpatient care provided to any participant in, or beneficiary of, an ERISA employee benefit plan;

(iii) declaring that ERISA preempts Section 346 of the Act and renders it unenforceable insofar as it imposes the HMO Surcharge on hospital bills for inpatient care provided to any participant in, or beneficiary of, an ERISA employee benefit plan;

(iv) declaring that FEHBA preempts Sections 346 and 348 of the Act, and Section 2807(c)(1)(b) of New York's Public Health Law, and renders them unenforceable insofar as they impose surcharges on hospital bills for inpatient care provided to any participant in, or beneficiary of, a FEHBA plan;

(v) permanently enjoining defendants from enforcing the laws which this Court has declared to be preempted and unenforceable as applied to ERISA employee benefit plan and FEHBA plan participants and beneficiaries;

(vi) awarding plaintiffs the costs of this action, including reasonable attorney's fees; and

(vii) granting such other and further relief as this Court may deem just and proper.

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Complaint of Plaintiff-Intervenor NYS Health Maintenance Organization Conference, et al., filed November 30, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

Plaintiffs, by their attorneys, Couch, White, Brenner, Howard & Feigenbaum, for their complaint, allege:

NATURE OF THE ACTION

1. This action seeks to invalidate a recently-enacted law of the State of New York on the grounds that it is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which (with exceptions not applicable here) expressly supersedes all state laws and regulations "insofar as they . . . relate to any employee benefit plan" covered by ERISA.

2. Under the Omnibus Revenue Act of 1992 ("the Act"), New York imposes an assessment of up to 9% on the cost of inpatient hospital care of persons who belong to HMOs.

3. In New York, a substantial number of the persons subscribing to HMOs receive that coverage pursuant to employee benefit plans subject to ERISA. The primary effect of the 9% assessment is to increase the cost of benefits paid out by ERISA employee benefit plans that use HMOs to provide health coverage for their participants and beneficiaries.

4. The inevitable effect of the assessment is to increase the cost of employee benefit plans that contract with HMOs, reduce the coverage provided by such employee benefit plans, or force employers and plan administrators to choose other means for funding employee benefit plans. The assessment therefore will force employers or plan administrators to tailor their ERISA employee benefit plans to the peculiarities of New York law.

5. The 9% assessment has a direct and substantial effect upon ERISA employee benefit plans. Thus, it is a law that "relates to" employee benefit plans and is superseded by ERISA and rendered invalid under the Supremacy Clause of the United States Constitution.

JURISDICTION AND VENUE

6. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 in that the dispute arises under the Supremacy Clause of the Constitution of the United States, and the suit is also brought pursuant to 29 U.S.C. § 1132(a)(3). Plaintiffs seek declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202.

7. Venue is proper pursuant to 28 U.S.C. § 1391(b) and 29 U.S.C. 1132 (e) (2) in that defendants Salvatore R. Curiale and Robert Abrams reside in the Southern District of New York, a substantial part of the events giving rise to the claim have occurred and continue to occur in the Southern District of New York, and employee benefit plans that are the subject of this lawsuit are administered there.

PARTIES

8. Plaintiff, the New York State Health Maintenance Organization Conference ("NYSHMOC") , is an association of 27 health maintenance organizations ("HMOs"). In the aggregate, these HMOs serve approximately 2.5 million people in

57 counties in the State of New York. NYSHMOC represents the interests of HMOs and their members on matters of policy concerning health care.

9. HMOs are providers as well as insurers of health care. Individuals and families generally become members of HMOs by enrolling through their employer or union welfare fund. Other members join through direct pay, Medicare or Medicaid programs.

10. Plaintiff Capital District Physicians' Health Plan, ("CDPHP") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, CDPHP provides health care and insurance for its own employees. In many cases, the benefits provided by Capital District Physicians' Health Plan are provided as part of an employee benefit plan.

11. Plaintiff ChoiceCare Long Island ("ChoiceCare") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, ChoiceCare provides health care and insurance for its own employees. In many cases, the benefits provided by ChoiceCare Long Island Plan are provided as part of an employee benefit plan.

12. Plaintiff Health Services Medical Corporation, ("HSMC") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its own members. In addition, HSMC provides health care and insurance for its own employees. In many cases, the benefits provided by HSMC are provided as part of an employee benefit plan.

13. Plaintiff Independent Health Association, Inc.,("Independent Health") is a not-for-profit corporation

certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Independent Health provides health care and insurance for its own employees. In many cases, the benefits provided by Independent Health are provided as part of an employee benefit plan.

14. Plaintiff Mid-Hudson Health Plan ("MHP") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, MHP provides health care and insurance for its own employees. In many cases, the benefits provided by MHP are provided as part of an employee benefit plan.

15. Plaintiff MVP Health Plan, ("MVP") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, MVP provides health care and insurance for its own employees. In many cases, the benefits provided by MVP are provided as part of an employee benefit plan.

16. Plaintiff Oxford Health Plans, ("Oxford") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Oxford provides health care and insurance for its own employees. In many cases, the benefits provided by Oxford Health Plans are provided as part of an employee benefit plan.

17. Plaintiff Physicians Health Services of New York ("PHS") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, PHS provides health care and insurance for its own employees. In many cases, the benefits provided by Physicians Health Services are provided as part of an employee benefit plan.

18. Plaintiff Preferred Care is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Preferred Care provides health care and insurance for its own employees. In many cases, the benefits provided by Preferred Care are provided as part of an employee benefit plan.

19. Plaintiff Travelers Health Network of New York, Inc., ("Travelers") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Travelers provides health care and insurance for its own employees. In many cases, the benefits provided by Travelers Health Network of New York are provided as part of an employee benefit plan.

20. Plaintiff U.S. Healthcare, is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, U. S. Healthcare provides health care and insurance for its own employees. In many cases, the benefits provided by U.S. Healthcare are provided as part of an employee benefit plan.

21. Plaintiff Wellcare ("Wellcare") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition Wellcare provides health care and insurance for its own employees. In many cases, the benefits provided by Wellcare are provided as part of an employee benefit plan.

22. Defendant Mark Chassin, M.D. is the Comissioner of Health of the State of New York. The Department of Health of the State of New York (the "Department of Health") is charged with administering the 13% surcharge imposed by the Statute and the 11% surcharge imposed by the Act. Defendant Chassin maintains an office at 125 Worth Street, New York, New York 10013.

23. Defendant Mary Jo Bane is the Commissioner of Social Services of the State of New York, and is charged with administering the surcharges on HMOs imposed by the Act. Defendant Bane maintains an office at 40 North Pearl Street, Albany, New York 12243.

24. Defendant Salvatore R. Curiale is the Superintendent of Insurance of the State of New York. Pursuant to Section 335 of the Insurance Law of the State of New York, defendant Curiale is empowered to prescribe and enforce rules and regulations governing insurance procedures that relate to the implementation of the hospital reimbursement provisions of the Public Health Law, including reimbursements giving rise to surcharges at issue in this litigation. Defendant Curiale maintains an office at 160 West Broadway, New York, New York 10013 which is his official residence.

25. Defendant Robert Abrams is the Attorney General of the State of New York, and is charged with enforcing compliance with the State's laws and regulations, including those at issue in this litigation, under New York Executive Law § 63 (1) and (12). The Attorney General maintains an office at 120 Broadway, New York, New York 10271 which is his official residence.

26. Defendant Mario M. Cuomo is the Governor of the State of New York, and is being sued in his official capacity as the Governor.

HMOs AND THEIR ROLE IN NEW YORK'S HEALTH CARE SYSTEM

27. HMO coverage differs from traditional health insurance. By combining hospitalization coverage with the provision of care, HMOs have the incentive to provide high quality health care in a cost efficient manner. HMOs accomplish this through a variety of contractual arrangements with doctors, other providers

and hospitals. For example, some HMOs (group and staff models) employ their own physicians. Other HMOs (individual practice associations or "IPAs") use networks of physicians who agree to serve the HMO's subscribers and adhere to the HMO's practice and payment guidelines.

28. HMOs generally do not themselves provide in-patient hospital care. Rather, HMOs typically operate as third-party payors of in-patient hospitalization. The cost of hospital reimbursement is a substantial expense of the HMOs and therefore directly affects the cost of health care to employee health benefits plans for coverage of their employees.

29. In addition to being a provider of care, HMOs differ in other major respects from insurers. For example, unlike commercial insurers which have traditionally relied on experience rating, and unlike Blue Cross, which experience rates groups with more than fifty members, HMOs community rate everyone: large groups, small groups and individuals. HMOs also are required to open enroll all groups of five or more employees and last year served over 250,000 small group members.

30. HMOs are required by State law and regulations to offer a comprehensive benefits package. While each HMO's benefits package may have distinctive features, they all share an emphasis on primary and preventive care and cover a wide range of illnesses and conditions. Because of the State's regulatory requirements, HMOs may not revise their benefits packages at will and may not reduce their package beyond a certain level of benefits.

NEW YORK'S 9% ASSESSMENT ON HMOs

31. Under New York's Public Health Law, the State, with certain exceptions, requires hospitals to charge standardized payment rates for inpatient care. Public Health Law § 2807-c(1).

Under this system, medical procedures are divided into categories based on the patient's diagnosis, known as Diagnosis Related Groups ("DRG"s). Public Health Law § 2807-c(1) (a). Hospitals are required by law to charge, and payors are required to pay, the DRG rate applicable to an insured patient's diagnosis, as adjusted by a formula reflecting costs specific to each individual hospital.

32. Under Section 2807-c(1) (b) of the Public Health Law, the DRG rate is increased by a 13% surcharge imposed on payments for inpatient services to patients covered by commercially insured and self-insured employee benefit plans. HMOs, Blue Cross and government plans like Medicare and Medicaid do not pay the 13% surcharge. The funds generated by the 13% surcharge are retained by the hospital.

33. HMOs are also allowed by statute to negotiate alternative rates with hospitals. N. Y. Public Health Law § 2807-c(2) (b) (i) (McKinney Supp. 1992). HMOs' ability to negotiate rates reflects a recognition that HMOs' managed care systems are able to reduce significantly the cost of hospitalization.

34. Section 346 of the Act amends New York's Public Health Law to impose an assessment of up to nine percent on the cost of inpatient hospitalization provided by HMOs. Section 346 also provides that the assessment may be reduced or eliminated for HMOs that enroll a certain number of Medicaid recipients in a managed care plan.

35. Pursuant to Section 346, beginning on July 1, 1992, each HMO must pay the 9% assessment, on a monthly basis, directly into a statewide pool established by the Commissioner of Health. This amount is thereafter deposited into the State's General Fund. The funds are not paid to hospitals.

THE IMPACT OF THE 9% HMO ASSESSMENT

36. In developing their health care benefits packages, many employee health benefit plans seek to provide a choice between indemnity insurance and HMOs. In addition, State and federal law requires employers (and employee benefits plans) to offer their employees the choice of at least one HMO.

37. The cost of hospitalization is approximately 30-40% of the overall cost of the HMO. Thus, the 9% HMO assessment raises the cost of providing health coverage through an HMO by as much as 3-4%. In the aggregate, the State projects that the 9% will generate approximately $32 million in the 1992-93 fiscal year. The HMO assessment thus directly increases the cost of providing hospital care to certain HMO subscribers enrolled pursuant to employee benefit plans.

38. As a result of the HMO assessment, administrators of employee benefit plans providing health care in whole or in part through an HMO (including plans covering employees of the intervenor HMOs) will be forced to pay more for HMO coverage or accept reduced HMO benefits. The HMO assessment therefore forces administrators or fiduciaries of employee benefit plans providing health and hospital coverage through an HMO, including plans covering employees of the intervenor HMOs, to tailor their ERISA plans to the peculiarities of New York law.

COUNT ONE

(ERISA PREEMPTS THE HMO ASSESSMENT)

39. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 38 above.

40. Section 346 of the Act, which imposes the HMO assessment, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

41. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, section 346 of the Act is preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

42. Plaintiffs are threatened with imminent irreparable harm.

43. Plaintiffs have no adequate remedy at law.

WHEREFORE, plaintiffs ask this Court for a judgment:

(i) declaring that ERISA preempts section 346 of the Act and renders it unenforceable insofar as it imposes a 9% assessment on the cost of inpatient care provided by an HMO to any participant in, or beneficiary of, an ERISA employee benefit plan;

(ii) permanently enjoining defendants from enforcing the laws which this Court has declared to be preempted and unenforceable as applied to ERISA employee benefit plan participants and beneficiaries;

(iii) awarding plaintiffs the costs of this action, including reasonable attorney's fees; and

(iv) granting such other and further relief as this Court may deem just and proper.

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of James M. Gutterman, filed August 21, 1992

[Travelers Ins. Co. v. Cuomo]

* * *

JAMES M. GUTTERMAN, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for inpatient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore F. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Division Vice President and Actuary, Managed Care and Employee Benefits. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers and the types of services which The Travelers provides to both insured and self-insured group health plans.

3. The Travelers and its affiliated and subsidiary companies constitute one of the world's largest multi-line insurance, financial and health services institutions. Among other services, The Travelers provides group accident and health insurance which it markets through group contracts to employers, employer associations and trusts, and other organizations ranging in size from small local employers to large multinational corporations. Under a typical group policy, the benefits provided by The Travelers include reimbursement of hospital, surgical and medical expenses, including coverage for inpatient hospital care. The Travelers also provides claims administration services for employer plans which are self-insured. With regard to the handling of claims for many such plans—both insured and self-insured—The Travelers is a fiduciary within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A).

4. In New York State, The Travelers provides either claims administration services or group accident and health insurance to over 430,000 employees and dependents covered by ERISA plans. The Travelers provides the above services or insurance in connection with 4,429 separate ERISA plans.

5. Under Section 2807-c of the New York Public Health Law, the rate of payment to general hospitals for inpatient hospital care in New York is regulated. Except in cases such as that of an uninsured person, the rates for inpatient hospital care are generally set on the basis of categories relating to the diagnosis of illness, known as diagnosis related groups or DRG's. Under the system, the amount charged for inpatient hospital care is set on the basis of the DRG into which the patient falls, rather than the actual cost of the treatment. In addition, as described below, the DRG amount is multiplied by a "payor factor" which creates a differential among the amounts charged to various payors such as a self-insured plan, health maintenance organization, commercial insurance company or a Blue Cross company. Under Section 2807-c(1)(b), the rate of general hospital reimbursement for pa-

tients "enrolled in a self-insured fund which provides for reimbursement directly to general hospital on an expense-incurred basis" is 113% of the applicable DRG rate. Thus, self-insured funds pay a surcharge of 13%, over and above the applicable DRG rate.

6. Under Section 2807-c(1) (b), as amended by Section 348 of the Omnibus Tax Revenue Act of 1992, the rate of general hospital reimbursement for a person "insured under a commercial insurer licensed to do business in [New York] and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on expense-incurred basis, and the insurer makes payments directly to the general hospital" is 124% of the applicable DRG rate. Thus, commercial insurers pay an aggregate surcharge of 24% over and above the applicable DRG rate. This aggregate consists of the 13% surcharge required by Section 2807-c(1)(b) of the Public Health Law, plus an additional 11% surcharge required by Section 348 of the newly-enacted Omnibus Tax Revenue Act of 1992.

7. The Travelers provides claims administration services in connection with 92 separate self-insured plans, providing benefits to over 280,000 persons subject to the 13% surcharge under Section 2807-c(1)(b). Ninety-one of these plans, providing benefits to 279,000 persons, are subject to ERISA. The Travelers provides health insurance, including coverage for inpatient hospital care, to 215,000 persons who are subject to the 24% surcharge under Section 2807-c(1)(b). Over 150,000 persons receive such coverage pursuant to 4,338 separate plans which are subject to the terms of ERISA. Thus, based on the experience of The Travelers, the vast majority of persons subject to the surcharges at issue are covered by an ERISA plan.

8. Many of the employers purchasing either claims administration services or group accident and health insurance from The Travelers operate and provide benefits to employees in more than

one state. The Travelers provides group accident and health insurance and/or claims administration services in connection with hundreds of ERISA plans which cover employees in both New York and other states. In many of the other states, the state does not require that a hospital charge different rates for inpatient hospital care provided to a person covered by commercial insurance or a self-insured plan.

9. The premiums charged by The Travelers for group insurance coverage reflect assumptions as to claims, investment returns and expenses, and a profit margin. As the costs of the medical treatment covered by The Travelers under a group policy increase, The Travelers passes the cost through to the employer by increasing the premium. Similarly, in the case of a self-insured plan, as the cost of the covered treatment increases, the amount of the claims administered by The Travelers and paid by the employer increases.

10. In addition to its group accident and health policies, The Travelers also provides excess risk insurance to self-insured group accident and health plans, which is known in the insurance industry as stop-loss coverage. Many self-insured ERISA plans purchase some form of stop-loss coverage to insure against catastrophic loss. The stop-loss policies issued by The Travelers usually provide either individual stop-loss coverage, aggregate stop-loss coverage or both. Under an individual stop-loss provision, The Travelers provides coverage only if the benefits paid by the plan during a policy year to any one individual exceed a specified individual trigger amount, which is set in the policy. Under an aggregate stop-loss provision, The Travelers provides coverage only if the aggregate benefits paid during the policy year exceed an aggregate trigger amount, which is set in the policy. Some of the stop-loss policies issued by The Travelers contain both individual and aggregate stop-loss provisions.

11. Under a stop-loss policy, until the amount of benefits paid by the plan exceeds the applicable trigger amount, The Travelers has no obligation to make payments to the plan. If and when the benefits exceed the applicable trigger amount, The Travelers is obligated under the policy to reimburse the employer for the amount of payments above the trigger amount. However, unlike a group insurance policy, The Travelers has no obligation to the employees or their dependents. In many instances, particularly with respect to aggregate stop-loss, the stop-loss programs administered by The Travelers operate for years without paying benefits over the applicable trigger amount.

12. B.H. Aircraft Company, Inc. ("B.H. Aircraft") is a New York corporation with its principal place of business in Farmingdale, New York. B.H. Aircraft is in the business of manufacturing aircraft parts, and conducts its operations in New York.

13. B.H. Aircraft provides group accident and health insurance to 122 employees under a plan which is subject to ERISA (the "B.H. Plan"). The Travelers has issued a policy to B.H. Aircraft which provides accident and health insurance to B.H. Aircraft's employees and their dependents (the "B.H. Policy") (a copy of the B.H. Policy is annexed hereto as Exhibit A). The B.H. Plan and the B.H. Policy provide coverage to 121 employees of B.H. Aircraft in New York and one employee in Connecticut. The Travelers pays claims made by employees of B.H. Aircraft and their dependents. With regard to the adjudication of such claims, The Travelers is a fiduciary of the B.H. Plan within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

14. The B.H. Policy includes coverage for the amount charged to an employee for inpatient hospital care. The Travelers sets the premium for the B.H. Policy once a year to reflect the cost of providing coverage, including the cost of inpatient hospital care. The 24% surcharge will undoubtedly increase the amount of the premium charged for group accident and health insurance for the

beneficiaries of the B.H. Aircraft Plan. The B.H. Policy is typical of the group accident and health insurance policies which The Travelers issues to employers in the State of New York.

15. Sheridan Catheter Corporation ("Sheridan Catheter") is a New York corporation with its principal place of business in Argyle, New York. Sheridan Catheter produces medical equipment and supplies. Its operations are conducted in New York, but Sheridan Catheter has sales employees located in the states of California, Georgia, Illinois, Maryland, Missouri, Ohio, Pennsylvania, Tennessee, Texas and Washington.

16. Sheridan Catheter has 242 employees. Two hundred and thirty-two of these employees are located in New York and the remaining ten are located in the other states listed in the foregoing paragraph. Sheridan Catheter provides group accident and health coverage for its employees under an employee welfare benefit plan (the "Sheridan Catheter Plan") subject to ERISA. Among other things, this plan provides coverage to Sheridan Catheter's employees for inpatient hospital care.

17. The Sheridan Catheter Plan is self-insured. The plan is funded by contributions from Sheridan Catheter itself, as well as periodic deductions from the pay of its employees. Thus, when a covered employee is reimbursed for the cost of inpatient hospital care, for example, this reimbursement is funded by Sheridan Catheter and its employees, rather than by an insurance company.

18. Sheridan Catheter has contracted with The Travelers to provide claims administration services. The applicable contract is known as an "Administrative Services Only" Agreement.

19. A copy of the Administrative Services Only Agreement currently in force between Sheridan Catheter and The Travelers is annexed hereto as Exhibit B. Pursuant to this Agreement, requests for benefit payments are made to The Travelers, which

then determines entitlements to plan benefits in accordance with the plan. Sheridan Catheter, however, must establish and maintain during the life of the Administrative Services Only Agreement (and for a reasonable period of time following its termination) a bank account for the payment of benefits to plan members. While The Travelers prepares the checks representing benefit payments made pursuant to the plan, it is Sheridan Catheter's responsibility to fund the bank account on which these checks are drawn.

20. To protect itself from catastrophic loss, Sheridan Catheter has purchased an excess risk contract from The Travelers, which is known in the industry as a stop-loss contract. A copy of the stop-loss contract currently in force between Sheridan Catheter and The Travelers is annexed hereto as Exhibit C.

21. Sheridan Catheter's stop-loss contract provides both individual and aggregate stop-loss coverage. Under the aggregate excess risk benefit provision of the contract, The Travelers' obligation to provide coverage is triggered only if the aggregate benefits paid by Sheridan Catheter during the applicable contract period exceed 125% of annual anticipated health care claims.

22. Under the individual excess risk benefit provision of the stop-loss contract, The Travelers provides coverage only in the event the benefits paid by Sheridan Catheter during the applicable policy period for any one employee or dependent exceed $90,000.

23. Unless the aggregate or individual excess risk benefit provisions are triggered, The Travelers simply administers claims on Sheridan Catheter's behalf using funds provided by Sheridan Catheter.

24. Pursuant to the terms of Sheridan Catheter's stop-loss contract, even when these points are reached, The Travelers has

no obligation to pay benefits to Sheridan Catheter employees. Instead, The Travelers reimburses Sheridan Catheter for the amount of payments above the applicable trigger amount.

25. Obviously, the 13% surcharge increases the amount of benefits the Sheridan Catheter Plan pays out. But this is not all. By increasing the amount of benefits Sheridan Catheter pays out, the administrative service charge due The Travelers is also increased. The Administrative Services Only Agreement specifically provides that Sheridan Catheter's monthly administrative service charge "shall be the sum of (1) 10.79% of the dollar amount of the drafts which would be issued by The Travelers pursuant to [the Administrative Services Only] Agreement, if the coordination of benefits provision were not applicable; and (b) 4.5% of the benefit payment reductions resulting from the application of the coordination of benefits provision of the Plan." Thus, the Administrative Services Only Agreement ties Sheridan Catheter's administrative service charge, in part, to the dollar amount of the drafts issued by The Travelers in a certain period of time. These drafts increase in dollar amount as hospital reimbursement rates rise due to added surcharges. It follows that adding surcharges to the rate of reimbursement for inpatient hospital care increases the periodic administrative service charge Sheridan Catheter must pay The Travelers.

26. The Sheridan Catheter Policy is typical of the stop-loss policies issued by The Travelers in order to provide excess risk insurance to self-insured plans. An employer's purchase of excess risk insurance to protect against catastrophic loss does not alter the fact that the plan is essentially self-insured.

WHEREFORE, it is respectfully submitted that The Travelers' motion for summary judgment should be granted.

JAMES M. GUTTERMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Thomas D. Musco, filed August 21, 1992

[HIAA v. Chassin]

* * *

THOMAS D. MUSCO, being sworn, states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am the Director of Statistics of The Health Insurance Association of America ("HIAA"). In that capacity, I am responsible for data collection and analysis through surveys of HIAA's member companies. I have been employed at HIAA for 21 years. I am fully familiar with the facts set forth below.

2. HIAA is a trade association organized to promote and protect the interests of its members, which are commercial writers of health insurance throughout the United States. According to the most recent data available to me, HIAA represents the interests of approximately 300 member companies that provide health coverage to approximately 85 million people in the United States.

3. On information and belief, HIAA's members also issue the great majority of the commercial group health insurance policies in the State of New York.

4. Employers who establish employee welfare benefit plans subject to the Employment Retirement and Income Security Act ("ERISA") provide health and hospital coverage to their em-

ployees by a variety of methods, including: (i) commercial health insurance policies; (ii) self-insurance (in which the plan is directly responsible for medical and hospital bills and may or may not carry excess liability coverage); (iii) subscriptions to a health maintenance organization ("HMO"); or (iv) coverage through a non-profit health insurer such as Blue Cross.

5. An ERISA plan using commercial health insurance contracts with an insurer which reimburses certain health care costs incurred by plan participants and their beneficiaries, in exchange for a premium calculated to cover the costs of paying claims and administering the policy.

6. ERISA plans that are self-insured directly assume responsibility for the costs of health care, including inpatient hospital care, for their participants. Under some self-insured plans, the employer covers the full cost of the covered health care, while in other instances contributions from employees are required. Employers frequently retain a commercial insurer to administer claims and perform other administrative functions for self-insured plans.

7. An HMO provides subscribers with comprehensive health care, including inpatient hospital coverage, from its designated providers for a predetermined periodic payment. Employers frequently contract with HMOs to provide medical coverage to employee welfare plan participants who choose to enroll in HMOs.

8. Blue Cross corporations are non-profit corporations organized under Article 43 of the New York Insurance Law which are distinguished from commercial health insurers under New York law.

9. Based on information provided to HIAA by our member organizations and on my experience in the industry, the vast

majority of the individuals who are covered by commercial health insurance in New York, as in the rest of the United States, are covered pursuant to employee benefit plans as defined by ERISA.

10. An independent study published earlier this year shows that of 158.3 million non-elderly Americans who have private health insurance, 138.7 million, or nearly 88%, receive such coverage through their employers. *See* Exhibit A attached hereto, excerpt from Foley, *Sources of Health Insurance and Characteristics of the Uninsured* (Employee Benefit Research Institute 1992).

11. Based on information provided to HIAA by its member organizations, many of the employee benefit plans that purchase commercial health insurance from members of HIAA to cover employees in New York also cover employees in other states.

12. HIAA is itself the fiduciary for an employee benefit plan subject to ERISA covering its own employees that provides commercially insured health and hospital coverage to former HIAA employees in New York State and to present and former employees in other states and the District of Columbia.

13. Many of HIAA's members also serve as claims administrators and claims fiduciaries for self-insured ERISA plans that provide inpatient hospital coverage to plan beneficiaries. Based on information provided to HIAA by its members, and my knowledge of the industry, some of the self-insured plans cover employees in states other than New York as well.

14. Based on my knowledge of the industry, most self-insured plans are employee benefit plans subject to ERISA.

15. Some of HIAA's members also own, in whole or in part, HMOs, organized pursuant to Article 44 of New York's Public Health Law. Based on my knowledge of the industry, such HMOs provide full health coverage, including coverage of inpatient

hospital care, to subscribers, many of whom are enrolled pursuant to employee benefit plans.

THOMAS D. MUSCO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Vincent W. Donnelly, filed August 21, 1992

[HIAA v. Chassin]

* * *

VINCENT W. DONNELLY, being sworn, states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am an actuary with the American Council of Life Insurance ("ACLI"). In that capacity I have been employed with ACLI for 17 years, with my primary responsibility in the area of group insurance. Prior to my employment with ACLI, I was employed for fifteen (15) years by three life insurers, having various group insurance actuarial responsibilities with each insurer. I am fully familiar with the facts set forth below.

2. ACLI is a trade association representing 611 companies, of which 125 are licensed to do business in New York.

3. ACLI's members, many of which also belong to Health Insurance Association of America (HIAA), write approximately 95% of the life insurance and about 80% of the commercial health insurance policies currently purchased in the United States and in the State of New York.

4. Based on my knowledge of the industry, the vast majority of individuals who are covered by commercial health insurance or

self funded plans receive such coverage through employer plans covered by ERISA.

5. ACLI itself is the fiduciary for an employee benefit plan that provides commercially insured health and hospital coverage to certain ACLI and HIAA employees and their dependents in New York, as well as to ACLI employees and their dependents in other states and the District of Columbia.

6. Some of ACLI's members serve as claims administrators and claims fiduciaries for certain self-funded ERISA plans in New York.

7. Some of ACLI's members also own, in whole or in part, health maintenance organizations ("HMO"s) organized pursuant to Article 44 of New York's Public Health Law. Such HMOs provide full health coverage, including coverage of in-patient hospital care, to subscribers. Based on my knowledge of the industry most HMO subscribers are enrolled pursuant to employee benefit plans subject to ERISA.

VINCENT W. DONNELLY

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Raymond A. D'Amico, filed August 21, 1992

[HIAA v. Chassin]

* * *

RAYMOND A. D'AMICO, being sworn, states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am the Senior Vice President and General Counsel of the Life Insurance Council of New York ("LICONY"). In that capacity, I am fully familiar with the facts set forth below.

2. LICONY is a trade association with 64 members organized to promote and protect the interests of its members—commercial writers of life insurance in the State of New York—some of which write health insurance policies.

3. On information and belief, LICONY's members—most of which also belong to the Health Insurance Association or the American Council of Life Insurance—write a significant percentage of the commercial health insurance policies in New York State, most of which are purchased pursuant to employee benefit plans. Some of those employee benefit plans are multi-state plans that cover employees in other states as well as employees in New York.

4. In addition, LICONY's members serve as claims administrators and claims fiduciaries for self-insured ERISA employee welfare benefit plans in New York. Some of those self-insured employee benefit plans are multi-state plans covering employees in New York and other states.

5. Two of LICONY's members own, in whole or in part, health maintenance organizations ("HMO"s) which provide health and hospital coverage to subscribers. On information and belief, those HMOs enroll a large number of subscribers pursuant to employee benefit plans.

6. LICONY is itself the fiduciary for an employee benefit plan that provides commercially insured health and hospital coverage to LICONY's employees in New York.

RAYMOND A. D'AMICO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Mark R. Welch, filed August 21, 1992

[HIAA v. Chassin]

* * *

Mark R. Welch, being sworn, states:

1. I am Director of the unit within the Actuarial Department of Aetna Life Insurance Company that has responsibility for financial arrangements and risk policy with respect to health coverage issued by Aetna Life to sponsors of large employee benefit plans. I am submitting this affidavit in support of the plaintiffs' motion for summary judgment. The statements in this affidavit are based on my personal knowledge and on business records of Aetna Life.

2. Aetna Life is a commercial insurance company authorized to do business in New York, and in all of the fifty States. Aetna Life insures or administers health care coverage for participants in employee benefit plans nationwide.

3. Employee benefit plans use various methods to provide coverage to their participants, including self-insurance and commercial insurance.

4. A self-insured employee benefit plan retains responsibility for providing funds to pay charges for medical care, including inpatient hospital care, furnished to participants in the plan. Frequently, such a plan retains a third party, such as an insurance

company, to administer the claims and to perform other related services. The sponsor of a self-insured plan may also purchase contractual liability insurance—which has come to be known in the industry as "stop-loss" coverage—entitling it to reimbursement from the insurer if the plan's claims exceed specified limits.

5. Alternatively, an employee benefit plan may choose to purchase commercial insurance to provide health benefits, including hospital coverage, to plan participants. When a plan is fully insured, the insurance company is responsible for funding all benefits. A hybrid arrangement (known as a "split-funded" arrangement) combines elements of self-insurance and insurance. An insurance policy outlines the insurer's liability under the arrangement, but there is also an administrative services agreement under which the employer is responsible for funding claims up to a maximum limit—in effect, a deductible under the insurance policy—with the insurer funding claims above the limit.

6. Aetna Life does business with both self-insured and commercially-insured plans covering participants in New York State. Specifically, Aetna Life sells claims administration and other services to self-insured employee benefit plans pursuant to administrative services contracts and sells commercial group health insurance to fully insured and split-funded plans. Administrative services contracts and commercial insurance policies issued to plans with more than 200 eligible employees cover approximately 1,020,000 individuals (employees and dependents) in New York.

7. I am advised that church plans and governmental plans are exempt from the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.* ("ERISA"). Of the 189 plans covering 200 or more eligible employees that were issued by Aetna offices responsible for New York State, less than 2% cover exempt church and governmental plans. Thus, it is my understanding that almost all of the plans for which Aetna Life provides administrative services or insurance are ERISA plans, and

that the great majority of individuals in New York State with respect to whom Aetna Life either issues commercial insurance or provides administrative services obtains health coverage through employee benefit plans covered by ERISA.

8. The plans for which Aetna insures or administers various forms of health coverage include a number of plans that have participants both in New York and in other states. For instance, Aetna administers coverage for approximately 46,000 employees of a large New York-based company, fewer than 10% of which are located in New York.

9. When the sponsor of an employee benefit plan purchases an administrative services contract from Aetna Life, the sponsor may elect to make final benefit determinations and to review claims for denied benefits, or it may choose (for a fee) to delegate those responsibilities to Aetna Life or to another third party. When the plan sponsor chooses the second option, Aetna Life acts as the plan's claims fiduciary for purposes of ERISA. Approximately 30-40% of the sponsors of self-insured plans covering participants in New York and administered by Aetna Life—including most of the largest such plans—have elected to designate Aetna as their claims fiduciary.

10. When Aetna Life issues commercial insurance covering members of an employee benefit plan, it is responsible for making final benefit determinations and reviewing claims for denied benefits. Accordingly, for purposes of ERISA, Aetna Life acts as the claims fiduciary with respect to the plan.

11. As noted, a self-insured employee health plan bears the full cost of providing plan participants with covered medical care, including charges for in-patient hospital care (although it may be reimbursed for claims exceeding the limit of any stop-loss coverage it may have purchased). Accordingly, the 13% surcharge that New York State imposes on in-patient hospital charges increases the amount that self-insured benefit plans must pay to provide

plan participants with benefits. The surcharge also increases the amount the plans must pay for stop-loss coverage. Because that coverage is rated on a regional basis (with New York and vicinity treated as a region), premiums for stop-loss coverage reflect the increased costs resulting from the 13% surcharge on hospital benefit payments.

12. The 13% surcharge and the 11% surcharge that New York has imposed on charges for in-patient care provided to patients with commercial insurance also increase the amounts that sponsors of plans to which Aetna Life has issued commercial insurance must pay for that coverage. Indeed, coverage for almost all plans with 200 or more eligible employees is provided under agreements that tie the plan sponsor's costs directly to the amounts actually paid for benefits to plan participants.

13. Those plans that are covered under split-funded arrangements bear the cost of the surcharges up to the limit of claims that are funded by the plan sponsor. In addition, commercial insurance, including the insured portion of a split funded arrangement, is usually provided to plans with 200 or more participants on what is known as an "experience-rated" basis. When an insured health plan is experience rated on a stand alone basis, the premium is dependent upon the amount paid to provide benefits to participants in that plan. If the total insured claims paid out under the policy at the end of the policy year and other costs of providing the insurance (including a certain level of profit) are less than the amount of the premium the plan has paid, the plan is eligible for a refund. If, however, the premium paid is less than the total of the insured claims paid and other expenses, there is a deficit, and the premium for the following year is adjusted to make up the shortfall. Under those arrangements, the burden imposed by the 11% and 13% surcharges is imposed directly on the employee benefit plan.

14. I am informed that certain plans for which Aetna Life has provided coverage have changed the form of their coverage in response to the 11% surcharge. Some have changed from a fully-

insured or partially-insured arrangement to an administrative services contract to avoid the surcharge.

MARK R. WELCH

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of John P. Burke, filed August 21, 1992

[HIAA v. Chassin]

* * *

John P. Burke, being sworn, states:

1. I am Financial Officer of the unit that sells group insurance (including health insurance) issued by Aetna Life Insurance Company primarily for employee benefit plans with fewer than 200 eligible employees. In that position, I participate in setting the premiums that Aetna Life charges for group health insurance covering those plans in New York State and elsewhere. I am submitting this affidavit in support of the plaintiffs' motion for summary judgment. The facts set forth below are based on my personal knowledge and on business records of Aetna Life.

2. In New York State, Aetna Life provides health coverage to approximately 1000 employee benefit plans with fewer than 200 eligible employees. Those plans cover approximately 32,000 employees and their dependents.

3. I am advised that church plans and governmental plans are exempt from the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.* ("ERISA"). I have reviewed a list of the plans with fewer than 200 eligible employees that are covered by commercial insurance issued by Aetna Life in New York State. Of the plans listed, fewer than 3% are churches or

governmental subdivisions. It is my understanding that the remainder are ERISA plans and thus, that the great majority of the individuals covered by Aetna Life's commercial insurance for groups of fewer than 200 eligible employees obtains that coverage through employee benefit plans covered by ERISA.

4. A number of those plans cover employees both in New York and in other States. For instance, plans for employees of Kason, Industries, Inc., Anco Engineers, Inc., and Wieland, Inc., among others, include employees in New York and other States.

5. When Aetna Life has sold commercial health insurance to the sponsor of an employee benefit plan, Aetna Life is responsible for making final benefit determinations and reviewing claims for denied benefits. Accordingly, my understanding is that Aetna Life serves as a claims fiduciary for those plans that are covered by ERISA.

6. Virtually all of the health coverage issued by Aetna Life in New York to sponsors of plans with fewer than 200 eligible employees is fully insured and prospectively rated. That is, the policies are written without employer self-insurance, and the premiums are set for the term of the policy, but may be increased when the policy is renewed.

7. In New York State, the premium that Aetna Life charges to a sponsor of a plan with fewer than 200 eligible employees for group health insurance is based, in large part, on the amount of claims made by participants in the plan in preceding policy periods (within limits allowed by New York State law), the amount of the claims by participants in other similar plans in the same area within the State, and anticipated changes in the costs of health care. Accordingly, increases in the amount paid for health care have a substantial effect on the premiums charged. In New York State, charges for in-patient hospital services make up about 35% of the total cost of claims covered by Aetna Life's group health insurance. Consequently, the 13% surcharge that New

York State imposes on in-patient hospital charges is reflected in the premiums charged by Aetna Life for commercial health insurance, and, as policies are renewed, the newly-enacted 11% surcharge puts upward pressure on those premiums.

JOHN P. BURKE

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Robert B. Shapland, filed August 21, 1992

[HIAA v. Chassin]

* * *

Robert B. Shapland, being sworn, states:

1. I submit this affidavit in support of plaintiff's motion for summary judgment. I am Vice President and Actuary of Mutual of Omaha Insurance Company ("Mutual of Omaha"), a mutual insurance company authorized to do business in the State of New York and in all of the 50 states. In my actuarial capacity, I am fully familiar with the facts set forth below.

2. In 1992, Mutual of Omaha wrote commercial health and accident coverage with allocable premiums in New York State of $99,401,907, including policies covering inpatient hospital charges on an expense-incurred basis.

3. In contrast to many large health insurers, the majority of individuals receiving health and accident coverage from Mutual of Omaha in New York are covered through individual insurance or through other plans not subject to ERISA. Nonetheless, the proportion of persons covered by Mutual of Omaha pursuant to ERISA Employee Welfare Benefit Plans is not insignificant (representing approximately 27% of premium volume).

4. Mutual of Omaha provides commercial insurance in New York to approximately 1,000 employee benefit plans, the vast

majority of which are subject to ERISA. Said plans cover approximately 23,500 employees and their covered dependents.

5. Mutual of Omaha also issues commercial insurance to employee benefit plans in states other than New York, which cover employees in New York. Conversely, many of the employee benefit plans purchased in New York cover persons employed in or residing in other states.

6. Mutual of Omaha has final authority to make claims decisions and thus, is a claims fiduciary for the commercial health and accident insurance plans it issues to employee benefit plans subject to ERISA both in New York and elsewhere.

7. Mutual of Omaha needs to charge higher premiums for commercial health and accident insurance issued in New York State and elsewhere as a result of the surcharges New York has imposed on hospital bills covered by commercial insurance.

8. Mutual of Omaha is itself the plan sponsor and is also a fiduciary for a self-insured employee benefit plan that provides health and accident coverage, including expense-incurred hospital coverage, to employees of Mutual of Omaha (and its subsidiaries and affiliates) residing in New York. This plan also covers Mutual of Omaha's employees in other states. As plan sponsor, Mutual of Omaha makes determinations on various issues affecting the plan including benefit level, continuation of the plan, and decisions on funding such as whether to utilize commercial insurance or self-insurance.

9. The 13% surcharge imposed by Section 2807-c(1)(b) of New York's Public Health Law directly increases the cost of covering claims under Mutual of Omaha's self-insured plan.

ROBERT B. SHAPLAND

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of James R. Hibbitts, filed August 21, 1992

[HIAA v. Chassin]

* * *

JAMES R. HIBBITTS, being sworn states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am the Vice President of Group Administration of The Union Labor Life Insurance Company ("Union Labor"), a commercial insurance company licensed to do business in New York and in all 50 states. In that capacity I am in charge of managing Union Labor's entire group life and health insurance operation, which primarily markets employee benefit plans subject to ERISA. I am fully familiar with the facts set forth below.

2. Union Labor has in force group health insurance coverage policies containing hospital coverage issued to employee benefit plans located in New York State.

3. Some of those plans are multi-state plans that cover employees in other states as well as in New York.

4. Union Labor is itself the fiduciary for a commercially-insured employee benefit plan that provides health and hospital coverage to employees of Union Labor and its affiliates residing

in New York. That plan also covers Union Labor's employees in other states and the District of Columbia.

JAMES R. HIBBITTS

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Thomas L. Reddy, Sr., filed August 21, 1992

[HIAA v. Chassin]

* * *

THOMAS L. REDDY, SR., being sworn, states:

1. I submit this affidavit in support of plaintiffs' notion for summary judgment. I am the Chairman of the Board of Trustees of the Professional Insurance Agents of New York, Inc. Trust ("PIA Trust"). In that capacity, I am fully familiar with the facts set forth below.

2. PIA Trust is the fiduciary for a commercially-insured employee welfare benefit plan subject to ERISA that provides benefits, including health and hospital coverage, to members of the Professional Insurance Agents of New York State and to similar groups in New Jersey and Connecticut.

3. The Board of Trustees of PIA Trust has responsibility for determining the form and scope of coverage provided by the Trust to its beneficiaries.

4. PIA Trust provides health and hospital coverage for approximately 4,000 plan beneficiaries in New York State and approximately 5,600 plan beneficiaries in New Jersey and Connecticut.

5. The 13% and 11% surcharges imposed under New York's Public Health Law on bills for in-patient hospital care covered by commercial insurance will inevitably increase the cost of premiums for health insurance to cover health and hospital care for the beneficiaries of PIA Trust in New York State by 24%.

THOMAS L. REDDY, SR.

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Angelo V. D'Ascoli, filed August 21, 1992

[HIAA v. Chassin]

* * *

Angelo V. D'Ascoli, being sworn, states:

1. I am Executive Director of Aetna Health Plans of New York, Inc. ("Aetna Health Plans"), a health maintenance organization that is licensed under Article 44 of New York's Public Health Law to do business in that State. I am responsible for overseeing Aetna Health Plans' operations. I am submitting this affidavit in support of the plaintiffs' motion for summary judgment. The facts stated below are based on my personal knowledge and business records of Aetna Health Plans.

2. Aetna Health Plans provides health coverage, including in-patient hospital benefits, to its 11,700 members in New York. Over 99% of those members have been enrolled pursuant to agreements between Aetna Health Plans and employers sponsoring employee benefit plans. Under those agreements, the employer agrees to pay a specified rate for each employee who enrolls in Aetna Health Plans (plus, if the employee elects and the plan permits, an additional amount to cover dependents).

3. Some of the employee benefit plans whose New York participants may enroll in Aetna Health Plans also include participants in other States. For instance, enrollment in Aetna Health Plans is

offered as an option to participants in Aetna Life's multi-state plan who reside in Aetna Health Plans' service area.

4. I am advised that governmental plans and church plans are exempt from the Employee Retirement Income Security Act of 1974 ("ERISA"). Only 1.7% of Aetna Health Plans' members are participants in governmental plans; none of its members are participants in church plans. It is my understanding, therefore, that the remainder are members of ERISA plans.

5. Aetna Health Plans is responsible for making final benefit determinations and reviewing claims for denied benefits by its members. Accordingly, my understanding is that Aetna Health Plans acts as claims fiduciary, for purposes of ERISA, with respect to those members who are covered by that statute.

6. Aetna Health Plans is subject to the 9% surcharge imposed by Section 346 of New York's Omnibus Revenue Act of 1992 on charges for in-patient hospital services rendered to HMO subscribers.

7. Rates charged by Aetna Health Plans are subject to prior approval by New York's Department of Insurance. In its applications for rate approval, Aetna seeks rates calculated to recover its health-care costs (hospital costs, physician costs, and miscellaneous medical costs), administrative costs, and some profit. The overwhelming majority (about 80%) of those items is the actual cost of health services, and in-patient hospital charges account for approximately 35% of that cost. Thus, the 9% surcharge will significantly increase the amount Aetna Health Plans must charge to recover its costs.

ANGELO V. D'ASCOLI

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Steven C. Anderman, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

STEVEN C. ANDERMAN, being duly sworn, deposes and says:

1. I am a Deputy Director of the Office of Health Systems Management ("OHSM"), New York State Department of Health ("Department"). I have supervisory responsibility over OHSM's Division of Health Care Financing, including the hospital reimbursement rate setting process, and I am accordingly familiar with the facts hereinafter set forth. I make this affidavit in opposition to plaintiffs' motions for summary judgment and for a preliminary injunction and in support of defendants' cross-motion for summary judgment.

INTRODUCTION

2. Plaintiffs allege that certain provisions of New York Public Health Law ("PHL") -2807-c are preempted by the federal Employee Retirement Income Security Act ("ERISA") and/or the Federal Employee Health Benefits Act ("FEHBA"). The challenged provisions are: (a) the 13% differential hospitals are generally required to apply to the inpatient hospital bills of patients covered by third party payors other than Medicare, Medicaid, health maintenance organizations ("HMO's"), and/or Blue Cross

plans (-2807-c(1)(b)), (b) the additional 11% differential hospitals are required to bill for patients covered by commercial health insurance carriers (-2807-c(11)(i)), and, (c) the contingent variable differential (0% to 9%) hospitals are required to bill for patients covered by HMO's (-2807-c(2-a)).

3. Plaintiffs claim that these differentials are preempted by ERISA because they increase the prices hospitals charge patient beneficiaries of plaintiffs' ERISA plan customers and thus tend to increase the health coverage costs of such ERISA plans. It is the Department's position, as set forth below in more detail, that these differentials are essential to promote important social policy goals relating to health care and that the tenuous and remote impact on the cost of benefits of ERISA plans is an insufficient basis for invoking preemption under ERISA. In regard to plaintiffs' FEHBA claim, I am advised by counsel that, contrary to plaintiffs' assertions, FEHBA's prohibition on any state "tax, fee, or other monetary payment" on payments made by FEHBA funds for health insurance coverage has no relevance or applicability to the differentials at issue herein.

HOSPITAL REIMBURSEMENT

4. Hospitals receive revenue for inpatient services from a number of sources. The largest payors in the system are Medicare, Medicaid and Blue Cross plans. Other payors include HMO's, commercial health insurance carriers, self-insured funds, the workers compensation and "no-fault" automobile insurers, and individual "self pay" patients. Medicare is a 100% federally funded and administered program whose hospital reimbursement rates are set directly by the federal government or its agents. Pursuant to PHL -2803(2), the Department is responsible for regulating rates and charges assessed by hospitals in regard to non-Medicare patients in accordance with methodologies authorized by PHL -2807-c.

5. The Medicaid program was established in 1965 pursuant to Title XIX of the Social Security Act, 42 U.S.C. -1396, *et seq.* It is a joint state and federal program to provide medical care to those who would otherwise be unable to afford such care. Under the terms of the Medicaid program, the federal government provides a percentage of the funding. In New York State, responsibility for the remaining monies is divided between the state and local governments. Pursuant to federal law, the Medicaid rate-setting methodologies employed by each state are subject to approval by the U.S. Department of Health and Human Services.

6. Blue Cross plans (of which there are several operating in New York) are not-for-profit health insurance corporations organized pursuant to Article 43 of the Insurance Law. They are closely regulated by the State and Blue Cross hospital rates have been subject to approval by the Department since 1966. Cost containment has been a primary factor in such rate approvals since at least 1969, when efficiency standards were incorporated into the rate setting criteria set forth in PHL -2807.

7. HMO's are organizations that provide or arrange for comprehensive health services to its members for a set, prepaid fee. They may be organized as either not-for-profit or for-profit entities. They are closely regulated pursuant to PHL Article 44.

8. Differentials in the cost of hospital services between Blue Cross plans and commercial carriers and self-insured groups have existed for many years in New York. Prior to 1988, commercial carriers and self-insured groups were deemed hospital "charge payors" and prior to 1978 hospital charges were not regulated. Between 1978 and 1982 only the rate of increase of such charges was regulated. Nonetheless, in the period prior to 1982 nearly all hospitals set hospital charges schedules at levels well in excess of their Blue Cross rate. Partly, this reflected Blue Cross plans prepayment and prompt payment policies, which benefited hospitals. It also reflected the fact that hospitals generally attempted to

make up any perceived shortfalls in their Medicare/Medicaid/ Blue Cross revenue by increasing their charges.

9. In 1978 a decision was made to actively investigate the possibility of a major restructuring of hospital reimbursement in New York. One of the major participants in this investigation was a legislatively created commission, the Council on Health Care Financing, chaired by Senator Tarky Lombardi, Jr. This Council solicited information and recommendations from all interested parties, including the government, private insurers, the health care industry and the general public. In October of 1980 the Council issued a report entitled "Recommendations for Financing Hospital Inpatient Care." In his prefatory letter to Governor Carey, Senator Lombardi identified the Council's objective as "the establishment of a uniform mechanism for financing general hospital inpatient care, including methods of establishing equitable payments from all sources."

10. On pages 91-95 of its report the Council discussed "payment differentials among payors". It concluded that such differentials were "appropriate" as between cost-based (i.e., rate) payors and charge payors, but that "the current differential does not provide equitable payment from all sources". The Council noted that regional average differentials varied between 13% to 36%, with additional disparity stemming from payment rates negotiated by self-insured groups. The Council essentially recommended establishing a uniform differential, with limited exceptions for pre-existing reimbursement agreements between hospitals and self-insured groups. A copy of relevant portions of the Council's report is annexed hereto as Exhibit A.

11. By 1982 the average differential or surcharge paid by charge payors amounted to about 25% over and above the cost-based Blue Cross rates. This was the statewide average. In some areas of the state, however, the differential approached 40%. Some charge paying groups were able to use their group buying

power to negotiate lower rates with individual hospitals. However, while this was obviously to the advantage of those groups, it simply threw more of a burden on the remaining charge payors and/or had a negative impact on hospital financial stability.

12. Based in part on the Council's report, a new, comprehensive hospital reimbursement system was instituted in 1983. It was called New York's Prospective Hospital Reimbursement Methodology ("NYPHRM"). New York secured special permission from the federal government to set hospital *Medicare* rates for a three year period (1983-1985). In addition, relevant statutes and regulations were amended to more closely regulate hospital charges, including those covered by commercial carriers and self-insured groups. The overall goal of NYPHRM was to establish a coherent, integrated reimbursement system encompassing all classes of payors that provided adequate revenue to hospitals while promoting important social policy objectives (such as affordable health insurance) and efficiency in the provision of hospital services.

13. During the 1983-1985 period (generally referred to as "NYPHRM I") governmental inpatient hospital rates (including Medicare and Medicaid), Blue Cross rates and HMO rates were computed in accordance with methodologies which provided for uniform average *per diem* rates of payment for each day of hospital care rendered to eligible patients, regardless of the individual circumstances of each patient's care needs. Commercial health insurance carriers and self-insured groups continued to pay hospital charges, but hospitals were legally required to apply their inpatient charges uniformly to all charge payors at a level not to exceed 115% of their Blue Cross rates. This prohibited hospitals from negotiating "discount" charges with particular payor groups, while also preventing the hospitals from charging anyone more than 115% of their Blue Cross rate. The practical result was to enforce a generally uniform 15% differential between Blue Cross plans and charge payors.

14. A self-insured ERISA benefit plan challenged this new charge control system in federal court on the ground it was preempted by ERISA. It was argued that the charges controls "related to" ERISA because they prevented self-insured ERISA plans from negotiating discount charges with hospitals and thus forced the plans to spend more money for hospital services. However, the U.S. Court of Appeals for the Second Circuit ultimately ruled that hospital reimbursement regulatory provisions of this nature did not "relate to" ERISA and thus lay outside the scope of ERISA preemption. *Rebaldo v. Cuomo*, 749 F.2d 133 (1984).

15. The State Hospital Review and Planning Council ("State Council") is an independent body within the Department which consists of 31 persons appointed by the governor and confirmed by the Senate. See PHL -2904. The State Council's duties include adoption of hospital reimbursement rules and regulations. See PHL -2803(2)(a). In May of 1985 the State Council's Charge Differential Analysis Committee submitted a report to the full State Council. A copy of this report is annexed hereto as Exhibit B. This committee investigated the need and utility of the differential between Blue Cross and charge payors. It concluded that the Blue Cross plans' open enrollment/community-rated premium policies were "achieving a key social policy objective, and that some significant differential is necessary for Blue Cross to maintain its current mix of low risk/high risk subscribers" (see p. 7 of the report).

16. Commencing in 1986, the federal government resumed direct control of Medicare hospital rate-setting. However, for 1986 and 1987 the other aspects of the new reimbursement system, including the generally uniform differentials described above, were maintained in place. This 1986-87 period is generally referred to as NYPHRM II.

17. Commencing on January 1, 1988, a new hospital reimbursement system was instituted in New York in accordance with PHL -2807-c and 10 NYCRR 86-1.50 *et seq.* This new system (generally referred to as NYPHRM III) is based on a "case payment" methodology in which hospitals are paid a set price for each inpatient treated and discharged. These set prices are based on historical average adjusted reimbursable costs of inpatient care as adjusted for inflation and vary depending on the characteristics of the patient and the illness treated. Each price is designed to reflect the anticipated average cost for that hospital to efficiently treat a particular class or category of patient. Each patient discharged from the hospital is assigned to one of 794 diagnostic related groups ("DRGs"). In turn, each DRG is assigned a service intensity weight ("SIW") reflecting the anticipated relative average amount of hospital resources required to efficiently treat patients in that DRG. The reimbursement for a particular DRG reflects the SIW assigned to that DRG.[1] A discussion of the case payment system is included in a report submitted to the State legislature by the Department entitled Hospital Reimbursement Case Based Rates of Payment for 1988, 1989 and 1990. A copy of the report is annexed hereto as Exhibit C.

18. Each DRG rate is the sum of a number of different elements, including an "operating cost component", a capital cost component, a bad debt and charity care assessment, a trend factor adjustment to account for inflation between the base year and the rate year, a factor reflecting the hospital's medical malpractice costs, a factor reflecting the excess medical malpractice costs of physicians practicing at the hospital, and one or more of the

[1]It should be understood that the reimbursement for each DRG will vary from hospital to hospital. This reflects two major factors: (a) approximately 45% of the historical cost data used to compute a hospital's DRG rates is derived from that hospital's cost history, which is unique to that facility, and (b) the portion of each hospital's rates which reimburses for capital costs is separately computed and based on each hospital's individual capital costs, as approved by the Department.

differentials, if applicable. Some hospitals also receive additional adjustments, such as a primary health service program adjustment and/or a financially distressed hospital adjustment.

19. Under the new DRG case based reimbursement system, the differentials between Blue Cross plans and commercial carriers and self-insured groups was set at 13% (though these latter two payors were not, under the new system, called "charge payors"). In February of 1989, the State Council's Charge Differential Analysis Committee submitted another report to the full State Council. A copy of this report is annexed as Exhibit D. Again, the committee concluded (on p. 4 of its report) that:

> The differential has been, and should continue to be, used as a vehicle - although not the exclusive vehicle - to achieve a number of key social policy objectives aimed at assuring the availability of broad and affordable health insurance and a vehicle to provide necessary working capital for hospitals.

20. Commencing in 1991 certain methodological amendments not relevant to the instant lawsuit were instituted and the methodology from 1991 to the present is generally referred to as NYPHRM IV.

21. Under the current provisions of PHL -2807-c(1) there are three categories of payors for hospital inpatient services. The first class of payors consists of "governmental agencies" (i.e., Medicaid), "corporations organized . . . in accordance with article 43 of the insurance law" (i.e., Blue Cross plans), and "organizations operating in accordance with [PHL Article 44]" (i.e., HMOs). Hospitals bill patients covered by this category of payors (hereinafter "category A") at the DRG case payment per discharge amounts. See PHL -2807-c(1) (a).

22. The second category of payors (hereinafter "category B") consists of workers compensation, the volunteer firefighters benefit system, the "no-fault" motor vehicle insurance system, commercial health insurance carriers, and self-insured groups making direct payments to hospitals on behalf of beneficiaries. Hospitals are required to bill patients covered by these payors at 113% (reduced to 111% if payment is made promptly—see 2807-c(11)(e)) of the DRG case payment per discharge amount. Patients with commercial insurance coverage are assessed an additional 11% differential. See PHL -2807-c (1) (b).

23. The third category of payors (hereinafter "category C") essentially consists of all payors who do not fall into the first or second category. Included in this category would be "self pay" patients, patients covered by self-insured groups that do not make direct payments to hospitals, and patients covered by commercial insurance policies that do not pay on an expense incurred basis. Payors in this category pay hospital "charges" (i.e., prices) for the particular hospital services actually utilized by the patient. The sum of the charges billed to such payors may not exceed approximately 131% of the applicable DRG "price" that would otherwise apply to the patient in question.

24. The 13% differential (the "payment rate conversion factor") for category B payors dates from the inception of the DRG case payment system in 1988. The revenue generated by this differential is retained by the hospitals. The additional 11% adjustment factor (the "supplementary payment rate conversion factor" or "SPRCF") on the amounts hospitals are required to bill patients covered by commercial health insurance was added in 1992. See -348 of Chapter 55, Laws of 1992. (For all other category B payors the differential remained unchanged.) See PHL -2807-c(11) and 2807-c(14-e) .

25. The 11% SPRCF was added to the differential for commercial insurers because Blue Cross plans have experienced contin-

ued difficulty in retaining groups of low or average health risk subscribers in the face of the practices of commercial carriers, such as plaintiffs, which allow them to offer lower premiums to select groups with low health risks. This in turn has weakened Blue Cross plans economically and put at risk their continued ability to achieve the social objective of providing affordable health insurance to groups and individuals who might otherwise be unable to secure such coverage. Because of the State's own pressing fiscal needs, it was determined that the revenue generated by this 11% differential would be paid over by the hospitals to the State's general fund.

26. Pursuant to -346 of Chapter 55 of the Laws of 1992, PHL -2807-c was amended to provide for a contingent/variable differential of up to 9% to be added to the DRG rate billed by hospitals for non-Medicaid HMO patients. The revenue generated by this rate adjustment is paid over to the State's general fund. See PHL -2807-c(2-a) as further amended by Chapter 834 of the Laws of 1992. However, the statute also provides that this differential may be reduced or eliminated based on an HMO's enrollment of Medicaid patients. Elimination or reductions of the differential are also available if an HMO can demonstrate certain good faith efforts to expand its Medicaid enrollment. Of the thirty HMO's currently operating in New York, several have had their differentials eliminated or reduced in accordance with the criteria set forth in PHL -2807-c(2-a). It is the Department's hope and expectation that the continued operation of this law will result in substantially increased Medicaid enrollment in HMO's and in a concomitant increase in exemptions from the differential.

27. It is the State's policy to encourage the enrollment of Medicaid patients in HMO's because it is thought that the health care needs of Medicaid patients will be more effectively and efficiently addressed in a "managed care" setting. This policy is reflected, among other things, in the fact that HMO's are specifically prohibited from discriminating in enrollment on the basis of

"source of payment" (10 NYCRR 98.11(g)(7)). Thus, while one purpose of the differential on HMO rates is to generate revenue for the State, its ultimate and primary purpose is to encourage HMO's to enroll Medicaid patients.

PLAINTIFFS' CLAIMS

28. The gravamen of plaintiffs' contentions in this lawsuit is that the differentials are "related to" ERISA benefits plans (and are therefore preempted) because some ERISA plans have chosen to purchase commercial health insurance or HMO coverage from some of the plaintiffs and that said plaintiffs will be obliged to charge more for such coverage than they would if the differentials did not exist. Plaintiffs also claim to represent the interests of self-insured ERISA benefit plans who employ some of the plaintiffs as claims administrators and who chose to pay hospitals directly for services provided to their beneficiaries. Plaintiffs claim that the 13% differential "relates to" ERISA because, it is argued, in its absence, such self insured plans would pay less for hospital services for their beneficiaries. However, as set forth below, plaintiffs' arguments are not well founded.

29. The differentials are not legal obligations imposed on ERISA benefit plans. Rather, these differentials are simply part of a matrix of statutorily mandated State controls imposed on hospitals in New York. The challenged provisions of PHL -2807-c mandate what hospitals are legally required to charge various classes of payors. These provisions do not regulate the organization or benefit structure of ERISA benefit plans. Such plans are simply among the "vendees" in the marketplace for hospital services. Further, as such vendees ERISA plans currently purchase hospital services through all three of the above-described categories of payors under PHL -2807-c. Thus, some ERISA plans secure hospital coverage through Blue Cross or HMO's (category A payors). Other ERISA benefits plans secure commercial health insurance or are self-insured plans making direct

payments to hospitals (category B payors). Still other ERISA self-insured plans reimburse their individual beneficiaries, who pay hospitals according to their charge schedules (category C payors).

30. In addition to being free to select among payor mechanisms in all three payors categories under PHL -2807-c, ERISA benefit plans also remain free to structure their hospital benefits in accord with their resources and priorities. Nothing in -2807-c restricts their freedom in this regard. Thus, ERISA benefit plans may choose coverage that excludes some hospital services included in the DRG rate and responsibility for payment for those services devolves upon the patient. Such benefit plan coverage may also include deductibles, co-payment provisions, and/or maximum dollar amounts per day or per hospital stay, all of which require the individual patient/beneficiary to pay a portion of the hospital bill. Nothing in PHL -2807-c restricts the right of ERISA benefit plans to utilize some or all of these mechanisms to adjust the ultimate cost of their hospital services benefits. The key point here is that the nature and extent of benefits under ERISA plans are affected by many factors. The mere fact that State regulations of prices for hospital services may impact ERISA plans because such plans are one of many "vendees" in the market place for such services, cannot reasonably lead to the conclusion that the challenged differentials "relate to" ERISA.

31. Health care in general, and hospitals in particular, are subject to comprehensive state regulation in New York. In addition to regulating non-Medicare rates and charges, the State Hospital Code set forth detailed standards relating to hospital organization and operation. See 10 NYCRR Part 405. The Public Health Law further provides for state review and approval for the establishment, construction and/or expansion of hospitals in New York, for the deletion or addition of a hospital service or for major equipment purchases. See PHL -2801-a, 2802, 2803 and 2805. All of these state regulatory activities impact the cost and/

or availability of hospital services in New York-the same services which ERISA benefit plans seek to purchase on behalf of their members. Indeed in modern society, and especially in the area of health care delivery, state regulatory activity that affects the price of goods and services (whether directly or indirectly) is ubiquitous and cannot be avoided. Insulating ERISA benefit plans from such impacts is ultimately impossible and the attempt to do so will simply result in preemption that will be arbitrary and inconsistent.

CONCLUSION

32. The differentials under challenge in this lawsuit are key elements in New York's carefully structured and highly integrated hospital reimbursement system. They are firmly rooted in the State's statutorily mandated responsibility to regulate rates and charges for hospital services. Further, the 13% and 11% differentials reflect a long standing historical reality concerning the relationship between Blue Cross rates and prices paid by other payors. The mere fact that among vendees/consumers of these hospital services are patients covered by ERISA benefit plans or by FEHBA plans should not form the basis for eviscerating an essential State regulatory function relating to the health care system.

WHEREFORE, it is respectfully submitted that plaintiffs' motions for summary judgment and for a preliminary injunction should be denied and that defendant's cross-motions for summary judgment should be granted in all respects.

STEVEN C. ANDERMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of James W. Clyne, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JAMES W. CLYNE, being duly sworn, deposes and says:

1. I am a Deputy Superintendent of Insurance and make this affidavit in opposition to the motions by plaintiffs in the above actions for summary judgment and in support of defendants' motions for summary judgment. I have been employed by the New York State Insurance Department ("Department") since 1961 and, prior to my appointment as a Deputy Superintendent in 1976, served as Chief of the Health & Life Policy Bureau ("Bureau") from 1974 to 1976. I am responsible for supervision of the Albany operations of the Department, including supervision of the Bureau, which reviews and, in accordance with the New York Insurance Law ("statute"), approves the policies and rates utilized by the plaintiff-insurers in New York State.

2. Employers in New York that provide, as an employee benefit, coverage for health care costs usually utilize one of three vehicles: a policy purchased from a commercial insurer licensed under either Articles 41 or 42 of the statute; a contract purchased from a health service corporation, such as the Blue Cross and Blue Shield plans, licensed under Article 43 of the statute or a health maintenance organization ("HMO") authorized under Article 44 of the N.Y. Public Health Law; or self-insurance. The

terms and conditions of the policies issued by commercial insurers and health service corporations have historically been subject to close regulation by the Department, *e.g.*, N.Y. Ins. Law §§ 3221 and 4305, respectively. HMOs are subject to the joint oversight of Departments of Health and Insurance. N.Y. Pub. Health Law §§ 4406, 4409. While the benefits provided under self-insured programs were never subject to regulation by the Department, it did, until the enactment of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* (ERISA), regulate the financial condition of jointly administered employee welfare funds (former statute Article 3-A). At present, the Department's jurisdiction over such funds is restricted by ERISA to governmental and church plans which are not covered by ERISA and is exercised pursuant to Article 44 of the statute.

RELATION OF HOSPITAL RATE REGULATION AND INSURANCE REGULATION

3. While the benefits provided by employers are within the determination of the employer, except to the extent they are governed by collective bargaining agreements, many employers provide coverage for hospital care. The rates charged by hospitals in New York are subject to extensive regulation by the Health Department under Article 28 of the Public Health Law.

4. The Department also exercises authority over health service corporations and insurers who sell health insurance which has significant impact on health care. Pursuant to Article 43 of the statute, the Department approves the initial premium rates charged for community-rated contracts of health service corporations and premium rate increases for such contracts after a public hearing. In addition to premium rates, the Department approves all contracts between such corporations and their subscribers. N.Y. Ins. Law § 4308. The Department may, under § 4308, disapprove proposed premium rates which are "excessive, inadequate, or unfairly discriminatory." HMO rate setting is treated in

the same manner. N.Y. Pub. Health Law § 4406. The Department is also responsible for ensuring that Article 43 corporations maintain required statutory reserve funds for the benefit of their subscribers. N.Y. Ins. Law § 4310. Similar approval authority of health insurance contracts is given to the Department under Article 32 of the statute vis-a-vis commercial insurers. Thus, the Department must approve all health insurance policy forms prior to sale in New York State. N.Y. Ins. Law § 3201. With respect to premium rate-setting by commercial insurers, the Department reviews and approves either the rates themselves or the rating formula used by the insurer to set rates. N.Y. Ins. Law §§ 3201 and 4235. The Department may disapprove a health insurance policy form if the benefits provided therein are unreasonable in relation to the premium charged. N.Y. Ins. Law § 3201(c)(3).

5. Non-profit health service corporations, such as Blue Cross and Blue Shield plans (referred to herein collectively as "Blue Cross plans"), historically have provided open enrollment and other benefits to the public. This fact has been recognized for decades. A 1958 report commissioned by Governor Rockefeller, and prepared by Raymond Trussell of the Columbia University School of Public Health, traced the origins of non-profit health service corporations and noted that commercial insurers were originally "relatively or completely disinterested in selling hospitalization insurance." (Trussell Report, p.14, Exhibit "A" hereto). The report confirms that the purpose of the first non-profit health service plans was community-wide coverage for the general welfare of the public. Thus, generally speaking, these plans did not utilize experience rating (charging subscribers more or less depending on their utilization of benefits or chances of greater utilization of benefits) to set premium charges, thus providing affordable health insurance coverage on a broad scale. In exchange for these public services, these corporations have long been exempted from taxes, N.Y. Ins. Law § 4310(j), and the rates that hospitals charged them for hospital services provided to their subscribers has historically been lower than that charged by

hospitals to commercial insurance companies for services provided to their policyholders. *See* N.Y. Pub. Health Law § 2807-c(1)(b). The Trussell Report recognized that Blue Cross plans were traditionally given discounts by the hospitals.

6. In 1965, Governor Rockefeller appointed the Committee on Hospital Costs ("CHC") to study the problem of the increasing cost of hospital care and the resulting increases in Blue Cross rates which threatened the affordability of coverage for many. The Report concluded that the "higher cost of hospital care required a strengthening and extension of the sharing of risk," and thus, opposed, as being contrary to the interests of the community at large, any movement by Blue Cross plans to experience-rating, although it noted the pressure on Blue Cross to do so from competing commercial insurers that "do not practice community rating and are able to attract groups with favorable experience . . . ." (CHC Report, p.59, Exhibit "B" hereto). In sum, the differential historically reflected the Blue Cross plans contributions to important societal goals, availability and affordability of health insurance coverage.

7. In addition, as time went on, the differential reflected other beneficial Blue Cross practices, *e.g.*, pre-payment and prompt payment policies which gave hospitals financial stability. Because hospitals generally attempted to offset shortfalls in their Medicare/Medicaid/Blue Cross revenue by increasing their charges to commercial carriers, by 1982, the average differential paid by charge payors, which included commercial insurers, amounted to about 25% above Blue Cross rates, and in some regions was as high as 40%. Anderman Affid. ¶ 11. The differential has been codified in the Public Health Law since 1983, and has varied over time; the current differential provided for in Public Health Law § 2807-c(1)(b) is 13 percent and, in Public Health Law § 2807-c(11)(d), is 11 percent, for a total of 24 percent.

8. The differential has been a subject of constant study by the State and the Department has participated in these studies . In or about 1984, pursuant to former § 2803(2)(c) of the Public Health Law, the State Hospital Review and Planning Council ("SHRPC") studied the appropriateness of the differential. Given the Department's role in regulating Article 43 corporations and our concerns regarding the effect of any change in the differential on the availability of health insurance coverage, we examined the then-current system and reviewed underwriting practices of both non-profit and commercial insurers in order to decide whether and to what extent the differential should continue. A copy of the Department's submission to SHRPC in 1984 is annexed as Exhibit "C".

9. The Department found at that time that, under the then-current system, the Blue Cross plans were enrolling a substantial number of persons unable or least able to obtain health insurance coverage, and that the plans were able to do so because of the differential. (Exhibit "C", p.7). The commercial insurers that were surveyed by the Department (companies that wrote about 50% of the health insurance business in the state) either did not provide insurance to individuals or small groups or required evidence of insurability, added exclusions from coverage, or required additional premiums, because of the higher risks involved. The Department concluded that to continue the availability of health insurance coverage, "a hospital differential in favor of Blue Cross will have to continue" (Exhibit "C", p.7). If the differential were eliminated or reduced, the Blue Cross plans would not be in a position to make coverage available to those least able to obtain it and the government, through tax monies, would become the insurer of last resort through Medicaid or by subsidizing hospitals directly. The SHRPC agreed and concluded in its report that the differential should continue (Exhibit "D" hereto, p.3).

10. In 1988, the SHRPC, pursuant to legislative changes to the Public Health Law (L. 1988, ch.2), again requested the Department's input in its review of the appropriateness of the hospital differential. A copy of the Department's submission is annexed as Exhibit "E". At that time, we noted that, despite the increased availability of health insurance to individuals and small groups on a community-rated basis through open enrollment by the Blue Cross plans, the plans had actually experienced a reduction in the total number of subscribers covered by direct pay (individual and small group contracts) from 1983-1987. In addition, due to rising health care costs, substantial premium rate requests had been made by Blue Cross plans and HMOs over that period of time.

11. With respect to the availability of health insurance coverage, we also noted that commercial insurers and HMOs continued to not offer any health insurance contracts on an open enrollment basis, and commercial insurers offered health insurance to small groups only on the basis of strict medical underwriting which tended to result in the exclusion of substantial risks. These underwriting practices included requiring medical examinations, HIV tests and other tests, excluding entire groups if, *e.g.*, one employee was over the age of sixty or had more than $2,500 in claims in the prior year, and excluding entire occupations and industries from eligibility for coverage. The list of black-listed industries and occupations is long and has grown. It includes farming, fishing and logging, demolition work, messenger services, restaurants, parking lots, police and firefighters, window cleaners, florists, liquor stores, orchestras, actors, barber shops and beauty shops, blood banks, hotels, motels, taxi drivers and truckers.

12. With regard to open enrollment, data provided to the Department from the Blue Cross plans indicated that, in 1983, Blue Cross plans had a total direct pay subscriber enrollment of 752,834. That number decreased by 144,862 to 607,972 by 1987. As for small groups, in 1983, Blue Cross plans had 2,055,150

subscribers enrolled; in 1987, that number had fallen to 1,855,596 (Exhibit "E", p.3).

13. Based upon these findings, the Department adhered to its view that a hospital differential is needed to ensure that Blue Cross continues to enroll those unable or least able to afford coverage and it must be sufficient to keep the Blue Cross plans from changing their underwriting standards and moving towards experience rating to exclude higher risks. The SHRPC report agreed and recommended continuation of the differential (Exhibit "F", p.6).

14. Chapter 2 of Laws of 1988 established the differential at 13 percent, but also included provisions allowing for its reduction to 11 percent for any commercial insurer which offered continuous open enrollment. The Department was required to evaluate insurers performance under this new provision, to establish standards and criteria for determining whether any insurers were entitled to the reduction, and to report our findings and conclusions. Laws 1988, ch.2, § 335. On March 8, 1989, the Department promulgated Regulation No. 137, 11 NYCRR 42, which set forth open enrollment requirements for health insurers to qualify for the reduction. The Department issued two reports pursuant to this provision, one in December, 1989, and the other in October, 1990, in which we reported that no commercial insurers had taken advantage of the opportunity to qualify for a reduction in the 13 percent factor.

15. As time has gone on, the proportion of claims paid by Blue Cross plans which involve payment for in-patient hospital stays subject to the rate mechanism of the Public Health Law has decreased relative to the total of health care costs. In addition, the commercial insurers have continued to siphon off the best risk from Blue Cross' community-rated pools. Between 1987 and 1989, for example, Empire Blue Cross, the largest New York health services corporation, lost 110,000 direct pay subscribers and 440,000 group subscribers. Thus, the utility of the 13 percent differential in providing a "level playing field" to these corpora-

tions in their competition with commercial insurers which can selectively underwrite their risks has diminished. This has resulted in a competitive disadvantage of these not-for-profit corporations and an inability to maintain a mix of high, low and average risks.

16. In August, 1991, Empire Blue Cross applied for a rate increase and indicated its intention to begin to selectively underwrite some risks as of October 1, 1991. After an extensive public hearing in September, 1991, the Superintendent of Insurance deferred action on Empire's request and called upon the Legislature to take action to assist these corporations in competing with commercial insurers. A copy of the Superintendent's letter to Empire Blue Cross is annexed as Exhibit "G". The Superintendent recognized that Empire was faced with a decreasing statutory surplus and mounting underwriting losses, despite an average rate increase of 18.9% granted in early 1991, and that "more and more small groups with favorable claim experience are departing from Empire leaving a smaller and sicker" community pool (Exhibit "G", p.2). These difficulties result primarily from the fact that commercial insurers choose to insure only the healthiest customers, thereby keeping their premium rates down, and leaving Blue Cross plans with the poorest risks. However, the Superintendent concluded that he could not allow Empire to split its small group community-rated pool or to increase individual subscriber rates by as much as requested, up to 50 percent. He called upon the Legislature to enact legislation to address the problem of access to affordable health insurance.[1]

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[1]In legislative hearings held in 1991 and 1992 testimony addressed the need for additional help for Blue Cross. Representatives of the commercial insurers recognized that the 13 percent differential was intended to level the playing field for Blue Cross, but insisted that the 13 percent plus the Blue Cross tax exemption was sufficient to do that; no more help was needed. (Testimony of plaintiff HIAA before Senate Insurance Committee, Testimony of plaintiff LICONY before Assembly Small Business and Insurance Committees, Exh. "H").

17. On April 1, 1992, the Superintendent granted Empire a rate increase. A copy of the Opinion and Decision is annexed hereto as Exhibit "I". The Superintendent noted that, in 1991, Empire had experienced an underwriting loss of $174 million on its community-rated business with a net loss of $150 million. Without a rate modification, projections showed that Empire's reserves would fall below zero by mid-1992. One of the factors found by the Superintendent to contribute to the 1991 community-rated underwriting loss was the continuing decline in enrollment of small groups of under 50 persons. The number of small group contracts declined from 457,850 at December 31, 1990 to 373,691 at December 31, 1991. That loss, together with 1989 and 1990 losses of 131,529, significantly reduced the community-rated pool.

18. The Department's analysis of Empire and other non-profit health insurers demonstrates that if community-rated pools continue to lose enrollment and the rates continue to increase, the end result will be the unavailability and unaffordability of health insurance coverage causing many New Yorkers to be without health insurance protection and without a method of financing health care benefits. The Superintendent again, in his decision on Empire's rate request, called upon the Legislature to enact the Governor's proposed legislation. That proposal, as it related to community-rating and open enrollment, was enacted this year (Laws 1992, ch.501). Meanwhile, the increase to the commercial insurers' hospital reimbursement rate became part of the State's budget negotiations and it was enacted as part of the Omnibus Tax Revenue Act (Laws 1992, ch.55, § 348). Under that provision, the differential for commercial insurers *only* is increased by an 11 percent supplementary payment conversion factor for a one year period from April 1, 1992 to March 31, 1993, the State's fiscal year. These amounts are required to be deposited in the State's general fund.

19. The link between the differentials and the regulation of insurance marketplace has been demonstrated. Commercial insurers and HMOs have declined to accept individuals and small

groups for health insurance coverage on an open enrollment basis, and commercial carriers have generally experience-rated small businesses. Blue Cross plans, on the other hand, offer open enrollment to all individuals and small groups on a community-rated basis. Thus, poorer risks are forced to obtain coverage from Blue Cross plans which allows the commercial insurers to offer more competitive rates to the better risks which, in turn, depletes the number of better risks insured by Blue Cross. This, of course, has raised the costs of Blue Cross plans and forced them to request substantial rate increases. As a result, both individual and small groups have been dropping coverage, with the better risks moving to commercial insurers who offer lower premiums. This cycle, resulting in dwindling community pools and higher costs for Blue Cross subscribers, is partially offset through the application of the differentials which restore some measure of equality to the insurance marketplace by giving Blue Cross a competitive advantage which enables them to attract good risk customers seeking lower payments to hospitals. Were it not for the differentials, the inability to attract good risk customers would result in a smaller and smaller risk pool, comprised of predominantly poorer risks causing higher premium rates and the deterioration of a viable health insurance system. As such, both the 13 percent and the 11 percent differentials are exercises of New York's long-standing authority to regulate insurance.

DEPARTMENT'S REGULATION OF STOP-LOSS INSURANCE POLICIES

20. Beginning in the 1970's (and in more limited fashion in the 1960's) some employers that had opted to fully insure their employee benefits turned to various new insurance products to minimize their costs, especially the cost of premium taxes, and subsequently to avoid mandated benefit laws. An employer may enter into administrative services only ("ASO") contract with a third party administrators ("TPA"), including insurers, whereby the claims are determined by the TPA and paid on behalf of the employer by the administrator utilizing funds provided by the employer. Such employer may also purchase excess risk insur-

ance, also known as stop-loss coverage, whereby an insurer will pay losses above a specified amount. Usually a commercial insurer enters into both ASO and stop-loss contracts with an employer. Plaintiff Travelers Insurance Company ("Travelers") has done this with the Sheridan Catheter Corporation ("Sheridan") whose ASO and stop-loss contract is annexed as Exhibits "B" and "C" to the affidavit of James Gutterman submitted with Travelers' motion papers.

21. Stop-loss contracts usually provide that the insurer will reimburse the employer if claims exceed a specified amount within a period of time, either on a per claims basis or in the aggregate. Usually, the insurer has no direct obligation to the employee and is merely obligated to pay claims on behalf of the employer under the ASO contract and reimburse the employer under the stop-loss contract. Sheridan's stop-loss contract has both an individual and aggregate threshold amount. If the benefits paid by Sheridan during the contract period for any one employee or dependent exceed $90,000, Travelers provides coverage. According to the Gutterman affidavit (although this is not apparent from the stop-loss contract itself), if the aggregate benefits paid by Sheridan during the contract period exceed 125% of anticipated health care claims, Travelers must provide coverage.

22. The Department has consistently taken the position that stop-loss contracts which reimburse an employer for medical and hospitalization expenses of its employees above certain amounts, while not a traditional type of insurance contract, are subject to the same requirements of law as are applicable to other accident and health insurance contracts providing hospital and medical coverage. The reasons the Department took this position are several. First, our analysis of the excess risk policies we reviewed showed that they provided benefits for expenses incurred due to sickness and disease. Such benefits are within the type of benefits covered by insurance contracts authorized by N.Y. Insurance Law § 1113(3) which covers accident and health insurance. In addi-

tion, the Department was concerned that employees may not realize that their employer has not purchased a traditional health insurance policy and may not understand the benefit coverage provided by the employer and the coverage provided by the excess risk insurer. Furthermore, the Department had other specific concerns about the sale of stop-loss policies: one, the Department was concerned the employees would not be provided with continuation of benefits due to financial impairment of the underlying employer plan. The Department determined that the excess risk insurer must be responsible for run-off claims and have sufficient reserves set aside to cover these risks. Finally, the Department was concerned that excess risk insurers not assist or acquiesce in any misrepresentation of benefits provided by the employer. The Department's Actuarial Information Letter 5, issued originally on June 27, 1985, was prompted by some of these concerns. The Letter sets forth the minimum requirements for the Department's approval of stop-loss policies. These requirements are directed solely at the insurer. The current version of the Letter is annexed as Exhibit "J".

23. An analysis of the Letter establishes that it constitutes a regulation of the insurer. Item 1 of the Actuarial Letter, dealing with mandated benefits and conversion policies respectively, are not intended to affect the provisions of an employer's plan subject to ERISA. The Department does not review the underlying ERISA plans and does not require changes in plans. The Letter requires only that the stop-loss insurer ensure that such benefits are covered and we accept the insurer's representation. The Department does not enforce this item against self-insured plans; its only recourse is to refuse to approve the stop-loss policy form. Item 2 requires the insurer to either provide conversion policy to an individual terminating coverage under the employers' plan in accordance with N.Y. Ins. Law § 3221(e) or by contracting with another insurer to do so. Again, this requirement is directed solely at the stop-loss insurer and has little or no impact on the underlying employer plan.

24. It is possible that the ASO or stop-loss contracts will provide that the insurer is obligated to continue to make payments for treatment incurred after the employer's plan terminates. These are usually referred to as runoff claims. Item 3 of the Actuarial Letter, dealing with notice of an insurer's obligation for runoff claims, requires that the insurer give notice to covered employees of the extent of insurer's obligation for runoff claims. Item 4 of the Actuarial Letter, dealing with responsibility for reserves for runoff claims, is intimately connected to the Department's authority over the financial condition of insurers. Item 5 of the Actuarial Letter, dealing with responsibility for runoff claims, reaches only the insurer, requiring it to assume responsibility for those claims unless replaced by another insurer, and imposes no obligation on an ERISA plan.

25. Item 6 of the Actuarial Letter, dealing with those groups that may be issued stop-loss contracts, is also directed only to the excess risk insurers and is consistent with the minimum participation requirements and eligibility requirements imposed on certain groups recognized in Insurance Law § 4235. Item 7 of the Actuarial Letter simply requires a rate filing by the stop-loss insurer. It is designed to ensure the financial stability of insurers and is part of New York's comprehensive regulation of insurance rates.

26. To the best of my knowledge, we have never received a complaint from either an employer or a self-insured plan administrator that the Actuarial Letter has prevented any insurer from issuing or any plan from purchasing stop-loss coverage.

27. Accordingly, the motions of plaintiffs should be denied and that of defendants granted.

JAMES W. CLYNE

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Stuart L. Lefkowich, filed October 2, 1992

[HIAA v. Chassin]

* * *

STUART L. LEFKOWICH, being duly sworn, deposes and says:

1. I am employed by the New York State Department of Social Services (Department) in the position of Assistant Commissioner. I serve as Director of the Bureau of Primary Care, Division of Medical Assistance. I am responsible for policy implementation relating to health maintenance organizations (HMO's) and managed care in the Medical Assistance (Medicaid) Program, established pursuant to Title 11 of Article 5 of the Social Services Law (SSL), Chapter 55 of the Consolidated Laws of New York.

2. I make this affidavit in opposition to Plaintiffs' motion for summary judgment and in support of Defendants' cross-motion for summary judgment.

3. The Medicaid Program is a joint federal-state assistance program for needy persons who cannot afford the expense of medical care. Title XIX of the Social Security Act (Act), 42 U.S.C. 1396 *et. seq.*, authorizes federal financial participation in the cost of furnishing medical care and services to eligible persons in accordance with a State Plan submitted by the state Medicaid agency and approved by the Secretary of the federal

Department of Health and Human Services as complying with Section 1902 of the Act, 42 U.S.C. 1396a.

4. The Department is designated as the Medicaid single State agency responsible for submission of a Medicaid State Plan to the Secretary of Health and Human Services and supervision of administration of the Medicaid Program in New York State (SSL 363-a).

5. Section 1903(m) of the Act, 42 U.S.C. 1396b(m), provides for federal financial participation, subject to stated conditions, in expenditures for Medicaid services furnished by HMO's. Section 365-a(2)(k) of the SSL authorizes Medicaid payment for comprehensive services furnished by HMO's "when such services are furnished in accordance with an agreement approved by the Department which meets the requirements of federal law and regulations."

6. Section 1915(b) of the Act, 42 U.S.C. 1396n(b), authorizes the Secretary of Health and Human Services to waive requirements of Section 1902 of the Act as necessary to permit a state "to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary . . ." Section 364-j of the SSL directs the establishment of managed care programs under which "[Medicaid] recipients receive [Medicaid] services directly and indirectly (including by referral) from a managed care provider, *including case management* . . ." (emphasis added).

7. Legislative enactments show an increasing emphasis by the New York State Legislature on inclusion of case management in Medicaid services delivery, both by HMO's and other provider

entities. In Chapter 904 of the 1984 Laws of New York, the Legislature declared: "It is the intent of the legislature to explore new approaches to the delivery of health services to beneficiaries of the medical assistance program that will assure quality medical care and that will improve the continuity and comprehensiveness of health services. Further, it is the intent of the legislature to broaden health care options for these beneficiaries to include primary physician case managers, conventional health maintenance organizations and new special purpose comprehensive health services plans as alternatives that can be voluntarily selected by beneficiaries."

8. In Chapter 710 of the 1988 Laws of New York, the Legislature added Section 364-j of the SSL to establish managed medical care demonstration programs. The State Commissioner of Social Services was authorized and directed to apply for any appropriate federal waivers. Managed care providers could include physicians, county health departments, providers of comprehensive health services plans (HMO's) licensed pursuant to Article 44 of the Public Health Law, Chapter 45 of the Consolidated Laws of New York, and hospitals and diagnostic and treatment centers. Primary responsibilities of the managed care provider included "management of the medical and health care needs of participants" and "referral, coordination, monitoring and follow-up . . ."

9. In Chapter 165 of the 1991 Laws of New York, the Legislature amended Section 364-j of the SSL to convert managed care from a permissive, demonstration concept to a mandatory program of general applicability throughout the State. The State Commissioner of Social Services was directed to prepare a State managed care plan providing for the implementation of managed care programs in social services districts and to designate, in succeeding years, approximately one-third of the social services districts in the State to develop managed care programs. After three years of managed care program implementation, only those

social services districts given specific exemptions would not have managed care programs. Social services districts implementing managed care programs would be required to establish incremental enrollment goals culminating in participation by 50% of the non-exempt Medicaid population within five years.

10. The legislative evolution of managed care in New York State has made case management of greater importance in the delivery of Medicaid services. Since the legislative declaration of 1984, HMO's have been the primary source of case managed care to Medicaid recipients in New York State. In 1992 to date, there are 23 HMO's offering Medicaid services. The other sources of Medicaid case managed care are 7 physician case management programs and 7 other non-HMO programs.

11. In April 1992, the New York State Legislature enacted subdivision 2-a of Section 2807-c of the Public Health Law, which was added in identical form by Section 95 of Chapter 41 of the 1992 Laws of New York, effective April 2, 1992 and Section 346 of Chapter 55 of the 1992 Laws of New York, effective April 10, 1992. In August 1992, subdivision 2-a was amended by Chapters 834 and 843 of the 1992 Laws of New York. Subdivision 2-a imposes a 9% factor, payable to a statewide HMO pool created by the State Commissioner of Health and credited to the State General Fund, upon rates of payment to general hospitals for reimbursement of inpatient hospital services furnished to subscribers of HMO's, excluding Medicaid eligibles and regional pilot project participants, and provides for an exemption from participation by an HMO in a social services district's Medicaid managed care program.

12. Subdivision 2-a acts as an incentive to HMO's to participate as managed care providers in the Medicaid Program, providing for an incremental reduction of the 9% factor by 25%, 50% and 75% if an HMO becomes a Medicaid managed care provider and enrolls like percentages of a target number of Medicaid

eligible persons and for elimination of the 9% factor if an HMO becomes a Medicaid managed care provider and enrolls at least 90% of a target number of Medicaid eligible persons. A significant increase in HMO Medicaid participation in 1992 is reflected by the number of HMO's with Medicaid contracts in the indicated years: 1988-2; 1989-5; 1990-9; 1991-13; 1992-23. Plaintiff Aetna Health Plans of New York, Inc. entered into a Medicaid contract with the New York City Human Resources Administration effective April 15, 1992 but has not enrolled a sufficient number of Medicaid eligible persons to qualify for reduction or elimination of the 9% factor.

13. The Legislature also provided in subdivision 2-a for an exemption mechanism relating to an HMO's failure to become a Medicaid managed care provider in a social services district by not entering into a managed care contract with such district. Subdivision 2-a states that an HMO "may apply to the state commissioner of social services on or before May first for the nineteen hundred ninety-two rate period . . . for an exemption from participation in managed care programs in a social services district on such bases as demonstration of a good faith effort to enter into a managed care contract with the social services district . . ." (Pub. H.L. § 2807-c(2-a) (b) (iii)). The effect of an exemption of an HMO from participation as a provider in a social services district's managed care program is that the HMO's service area is deemed not to include such social services district. Accordingly, no target number of Medicaid eligibles is calculated for that social services district. If an HMO receives exemptions from participation as a managed care provider in all social services districts in its service area, then the 9% factor to be imposed upon inpatient hospital service payments made by the HMO to general hospitals would be eliminated for the applicable rate period.

14. For the 1992 rate period, 21 HMO's have applied for exemption from participation in a social services district's man-

aged care program. Of those applications for exemption, seven have been granted, eleven denied, two granted in part and one is pending determination. Plaintiff Aetna Health Plans of New York, Inc. did not apply for exemption from participation for the 1992 rate period.

15. As a result of the granting of exemptions or enrollment of numbers of Medicaid eligible persons meeting target number percentages, eight HMO's qualified for elimination of the 9% factor for the 1992 rate period and two HMO's qualified for reduction of the 9% factor for the 1992 rate period.

16. Case managed care, authorized under the federal Social Security Act and delivered by HMO's as managed care providers, is becoming a primary element in the evolution of the New York State Medicaid Program as a source of high-quality, cost-effective care for needy persons and the 9% factor serves as an incentive to HMO's to participate in serving the Medicaid population.

By reason of the foregoing, the Plaintiffs' motion for summary judgment should be denied in its entirety and the Defendants' cross-motion for summary judgment granted.

STUART L. LEFKOWICH

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Arthur B. Klein, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

ARTHUR B. KLEIN, being duly sworn, deposes and says:

1. I am the Vice President of Provider Audit and Reimbursement for Empire Blue Cross and Blue Shield. As such, I am fully familiar with present and past hospital reimbursement schemes in the State of New York. I make this Affidavit in support of the New York State Conference of Blue Cross and Blue Shield Plans' and Empire's Cross Motions for Sumary Judgment in these actions.

2. The differentials here at issue are part of New York State's regulation of hospitals' costs, charges and reimbursement. The purpose of this Affidavit is to set forth some background as to the hospital reimbursement and rate setting scheme in New York.

3. New York's comprehensive regulation of hospital care, hospitals costs and reimbursement, and health insurance reflects its long-term commitment to hospital cost containment. That commitment is part of the State's responsibility to see that its citizens can afford the health care and insurance they need as well as provide aggregate financing to assure the viability of the hospital system.

4. The magnitude of the hospital system in New York is astounding. There are approximately 280 acute care, general hospitals in New York State. In 1991, the total revenues paid to those hospitals was approximately 20 billion dollars. Approximately $6 billion was attributable to the Federal government's Medicare program, with the remaining $14 billion subject to New York's hospital cost control law.

5. Pursuant to Public Health Law §2803(2)(a)(ii), the Commissioner is given the authority to approve rules and regulations adopted by the State Hospital Review and Planning Council establishing "schedules of rates, payments, reimbursements, grants and other charges for hospital and hospital related services . . . provided in twenty-eight hundred seven - c [the DRG legislation] of this Article."

6. Pursuant to Public Health Law §2807(2), payments to hospitals for inpatient services by the Plans, HMOs, the Medicaid program and other payors (except Medicare) must be at rates approved by the Commissioner. The Federal government's Medicare program has its own rate setting statutes and all references in this Affidavit to rates or payors exclude Medicare.

7. Prior to approval of such rates, pursuant to Public Health Law §2807-c(2)(b), the Commissioner must determine that the proposed rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

HISTORY OF HOSPITAL REIMBURSEMENT

8. Prior to 1970, hospitals were reimbursed on a retrospective, reasonable-cost basis. A hospital was reimbursed, within very general limits, for the actual cost of whatever care it rendered. Such retrospectively determined reimbursement did not provide motivation for hospitals to control their costs.

9. The rate of inflation in hospital costs quickly reached an unacceptable level, threatening to put adequate health care beyond the reach of many citizens of the State. The rising cost of hospital care threatened the public purse which financed the State's Medicaid program, as well as the millions of New Yorkers covered by Blue Cross health insurance.

10. In the face of the crisis caused by the spiraling inflation in hospital costs, the Legislature enacted the Hospital Cost Control Law of 1969. The new law applied to state and local government payments for the Medicaid program, as well as Blue Cross hospital insurance. The purpose of the law was clear from the legislative findings and purpose:

> Rising hospital costs are a matter of vital concern to the people of this state. The alarming increases in such costs encountered in recent years pose dangers to all purchasers of hospital services as well as hospitals themselves.
>
> * * *
>
> The legislature therefore finds and declares that *it is essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs.* It is the intent of this chapter to provide for uniform measures on a state-wide basis to control hospital costs without the sacrifice of quality of service. (Chapter 957, 1969 N.Y. Laws) (Emphasis added)

11. To achieve this goal, the Hospital Cost Control Law amended §2807 of the Public Health Law. The new law obliged the Commissioner to develop "an effective cost control program" which would "enable and motivate hospitals to control their spiraling costs," and directed the Commissioner to certify

only those payment rates to hospitals that are "reasonably related to the costs of efficient production of hospital services".

12. The Commissioner therefore developed regulations to establish a system of "prospective" reimbursement. Under prospective reimbursement, a payment rate is established for each hospital in advance of the rate year in order to give each hospital an opportunity to plan its budget accordingly. If, during the rate year, the hospital's cost of providing care is less than the payment rate, the hospital retains the difference. If the cost of care is greater than the payment rate, the hospital absorbs the difference. Thus, prospective reimbursement encourages the hospitals to make their own operations more efficient.

13. This system of prospective reimbursement, in which the Commissioner of Health, the Superintendent of Insurance, and Blue Cross have worked closely with the hospitals to help control their costs, has transformed New York from a state with one of the fastest growing rates of inflation in hospital costs to one with a rate of increase that consistently has been below the national average.

14. Over time the methods of reimbursement were refined and more sophisticated methods of determining hospital rates were developed. For example, rates were limited to the average cost of similar hospitals, even though the hospital in question may have spent considerably more. These reimbursement provisions were repeatedly challenged in court by hospitals, but were invariably upheld. *See Brooklyn Hospital v. Axelrod*, 97 A.D.2d 493 (2d Dept. 1983), *aff'd* 61 N.Y.2d 1012 (1984); *Jewish Memorial Hospital v. Whalen*, 47 N.Y.2d 331 (1979).

15. Many of the significant changes in hospital reimbursement methods coincided with the fiscal crises of New York City during the mid-1970s (since the City pays a large portion of Medicaid costs) and the fiscal crisis of New York State itself in the late

1980's. Throughout both the 1970's and the 1980's the cost of hospital care was a recurrent theme at the public hearings which the Superintendent of Insurance is required to hold prior to approving applications by Blue Cross and Blue Shield to increase premium rates (*See* N.Y. Insurance Law §4308).

16. By the late 1970's New York was rigorously regulating the hospital rates paid by the State Medicaid program, Blue Cross and Blue Shield and health maintenance organizations (HMOs). Other payors (such as workers' compensation, no-fault auto insurers, commercial insurers and self-insured plans) were paying hospital charges (which were limited to some extent by legislation) and sought to have the cost control laws to apply to them as well. On the other hand, hospitals argued that if all hospital rates were regulated without any margins for discretionary use of funds to cover the hospitals costs of caring for persons without health insurance, the hospitals would be placed in dire financial straits.

17. The Legislature adopted new legislation which attempted to meet both goals. Beginning in 1983, hospital rates became more regulated for all categories of payors, and by 1988 all payors received the benefit of the State's hospital cost control legislation. However, a factor was added to every hospital bill (now averaging approximately 5% for hospitals statewide) to compensate hospitals for bad debts and charity care incurred when rendering care to patients who had no health insurance and could not pay for that care out of their own pocket. The new legislation was referred to as NYPHRM—New York Prospective Hospital Reimbursement Methodology.

BACKGROUND OF PRESENT REIMBURSEMENT UNDER NYPHRM

18. Presently, the reimbursement rates for inpatient hospital care are established pursuant to §2807-c of the Public Health Law.

19. Under the NYPHRM system, inpatient rates are generally based on each hospital's costs expended during 1981, which is referred to as the base year. In each subsequent rate year, the fixed base year costs for 1981 are increased by up to three additional factors which are described below. *See* Public Health L. §2807-c(l)(d) and Regulation 86-1.50(e).

20. Each year the base year costs are increased by an inflation factor (called a trend factor), which is determined by a panel of economists. *See* Public Health Law §2807-c(10).

21. In some years, the base year costs may also be increased by appeals submitted by the hospitals. *See* Public Health Law §2807-c(9). Appeals are generally granted for services which the hospital has just begun to provide and therefore are not encompassed in the hospital's 1981 base year costs, or may be granted for unusual costs which are beyond the hospital's control, such as nursing salary increases which far exceed the trend factors.

22. In some years the Legislature decides that a fixed dollar amount should be added to the 1981 cost base of all hospitals located in the State. This occurred in 1988 and 1991. These additional statutory amounts added to the hospitals' fixed 1981 base year costs are referred to as enhancements. A methodology is prescribed to allocate the total value of the enhancements among the cost base of the various hospitals in New York State. *See* Public Health Law §2807-c(1)(e).

23. In summary, under the NYPHRM system, hospital inpatient rates are based upon the hospitals 1981 base year costs, plus trend factors for each year from 1982 to 1991, plus any appeals approved by the Commissioner, plus statutory enhancements to the cost base.

24. Until 1987, hospital inpatient rates were established on a per day basis. If a patient remained in the hospital for five days, the hospital was paid five times the per day rate.

25. Beginning in 1988, most rates were established on a per case basis. The hospital is paid a fixed amount for each patient stay, regardless of how long that patient remains in the hospital. That fixed amount per patient is adjusted due to the intensity of patient care, which is measured by the diagnosis which applies to that patient, according to a classification system known as Diagnosis Related Groups, or DRGs. *See* Public Health Law §2807-c(3). The rate is decreased for diagnosis reflecting low intensity of patient care or increased for diagnosis reflecting high intensity patient care.

The Eight Components Of The Rate

26. The typical hospital rates established under the current Public Health Law have eight distinct components: operating costs (for room and board, nursing, dietary, etc.), capital costs, the hospitals own malpractice insurance, bad debt and charity care, primary health service program, financially distressed hospitals' program, excess malpractice insurance paid for by the hospital for its physicians and a 13% additional portion (the differential). As of April 1, 1992, the additional portion for commercial insurers is 24%, rather than 13%. Each of these components is separately identified on rate sheets which the Department distributes to hospitals. Copies are provided to the various payors as well.

27. Each of these rate components, except for the differential, vary from year to year and therefore contribute to the amount paid by an insurer or payor to reimburse hospitals for rendering services.

28. The largest portion of the rate is for operating costs, such as room and board, nursing services, dietary department, etc. The operating cost component is an average amount which represents the average cost of treating a patient. Since it is an average, by definition a hospital spends more on some patients and less on others. As an incentive for hospitals to control their costs, the rate is based upon a variety of methods which limit reimbursement to the cost incurred by an average hospital. Hospitals that have costs higher than the average have a strong incentive to reduce costs since their reimbursement will be based upon an average rate that is less than their current costs. If a hospital's costs are less than the average reflected in the rate, the hospital is permitted to keep the difference, and that adds to the incentive to limit costs and the ability to provide better patient care.

29. In a complex rate setting system with these types of incentives to control hospital costs, it is almost impossible to identify the total cost of treating any one patient. Therefore, the Plaintiffs' statements that the rate setting system causes Plaintiffs to pay more than it costs hospitals to provide services to patients covered by the Plaintiffs is meaningless.

30. Within statutory parameters, the State increases hospital rates which costs the Plans and all payors more than if that adjustment had not been made.

31. For example, each year the component of the hospital's rate for operating costs is increased by a trend factor established by a panel of economists which is designed to account for inflationary trends (*See* Public Health Law §2807-c(10).) Obviously, hospital rates paid by insurers and self-insured plans would be lower if this trend factor was not applied to increase the rates each year.

32. Another example relates to rate adjustments based on quality of care factors. In 1989 the Commissioner of Health adopted new regulations that limited the number of hours which interns

and residents could work and required experienced physicians to be at the hospital to supervise the physicians in training (*See* 10 NYCRR Part 405). Since these changes in hospital staffing imposed additional costs on the hospitals, the Commissioner (pursuant to Public Health Law §2807-c(l)(f)) ordered that hospital rates be increased to reflect the additional costs. The total annual cost of the Part 405 adjustments for the first year of the new system was approximately $122 million.

33. A third example is the hospitals' capital costs. The Public Health Law requires that hospitals obtain the Commissioner of Health's prior approval of the scope and cost of capital construction. *See* Public Health Law §2802. The reimbursement provisions provide that the approved capital costs be included in the hospitals rate. *See* Public Health Law §2807-c (8). The result is that each time a hospital constructs a new wing, or undertakes extensive renovations, the commissioner's approval must be obtained and the additional capital costs are then added to the hospital's rate. This ultimately increases payments by all payors.

34. These examples demonstrate two important points: first, the State's hospital cost control efforts are intricately intertwined with its efforts to regulate the quality and availability of hospital care and to assure sufficient aggregate financing to maintain the viability of the hospitals. Regulations designed to improve the quality of care and the capital facilities utilized by hospitals are contingent upon methods to finance those improvements. If a State is not free to increase hospital rates in order to finance improvements in quality of care and capital facilities, then the State's ability to regulate the quality and availability of care is dramatically reduced.

35. Secondly, New York State has undertaken to regulate and limit hospital charges and that effort has been extremely successful; reimbursement to hospitals in New York has risen at a far more limited pace than in other states. There is no doubt that

payments to hospitals by the Plaintiffs are far less under the State's rate regulation scheme than if the hospitals were allowed to charge whatever amounts the hospitals decided to charge. That overall purpose (and indeed success) should not be obscured by Plaintiffs' focus on one small portion of the rate setting process.

36. In summary, the Plaintiffs have benefited enormously from the State's cost control effort. Plaintiffs would likely have paid literally millions of dollars more to hospitals in the absence of the State's cost control statutes and rate setting process. It is also important to note that the patients covered by the Plaintiffs have benefited from the readily available hospital care offered in New York State and the quality and technology offered by the hospitals in New York. The State's regulatory initiatives and oversight of hospitals, including the reimbursement system, are partly responsible for those benefits.

37. It is a truism to allege (as the Plaintiffs do) that inclusion of any particular component of the total rate costs insurers and payors more than if that component had not been included at all. Unless the Plaintiffs expect free care from hospitals, any rate setting by the State will cost insurers and payors more than if there was no rate at all or if the rate was lower. The real issue is whether a State has the regulatory authority to impose an overall cost control scheme in lieu of an unregulated market where the hospitals charge what they choose. If a State has authority to limit what hospitals charge to ensure a viable system of financing hospital care, then by practical necessity the State must have the authority to decide what the components of that rate setting process will be.

Payor Categories And The Differential

38. The current provisions of the Public Health Law identify or contemplate thirteen different types of payors that reimburse

hospitals. The statute classifies them into three different categories. *See* Public Health Law §2807-c(1)(a), (b) and (c).

39. The first category includes: Blue Cross and Blue Shield Plans, health maintenance organizations, and the State's Medicaid program. Payors in this category pay seven of the rate components established under the cost control law, but they do not have to pay the differential component.

40. The second category includes all other parties which the State has included in the cost control legislation: payments pursuant to the workers' compensation law (whether by an employer, insurer or other arrangement), payments pursuant to the volunteer firefighters' benefit law, the volunteer ambulance workers' law, the no-fault auto insurance law, persons enrolled in a self-insured fund which remits payment directly from the fund to the hospital, and persons insured by a commercial insurer (so long as the insurer is licensed in New York and the insurance coverage is "expense incurred", which means it covers all types of expenses incurred in the hospital (not just a fixed amount such as $50 per day). Payors in this category pay all the eight components of rates established under the cost control law, including the payment of the differential component.

41. The third category is not really subject to the same cost control law provisions. Parties in this category pay the hospital's charges rather than the State's reimbursement rate, although such charges can not be more than 20% higher than the state specified rate for the second category (which includes all eight components of the rate). Parties included in this category include: commercial insurers not licensed in this State; commercial insurers that issue coverage on a basis such as $50 per day; self-insured plans that do not remit payments directly to the hospital, and persons who have no health insurance or health benefits plan and thus make payment out of their own pocket.

42. The Plaintiffs are included in the cost control legislation and, like the majority of other payors subject to the cost control law, are in the second category. They pay all eight components of the rates established pursuant to that law. Therefore Plaintiffs are able to obtain the benefit of making payment to hospitals at the cost control rate rather than the essentially uncontrolled charges which the hospital is otherwise free to impose.

Choices Available To An Employer

43. It is important to note that in some of the instances identified in the complaints, the Plaintiffs are subject to the cost control statute only by their own choice. For example, a self-insured plan does not have to pay the cost control rate. If a self-insured plan chooses to remit its payments to the employee or patient (rather than directly to the hospital) then the self-insured plan is not subject to the State rate setting scheme and would not have to pay any of the eight components of the rate. In that event, the self-insured plan would pay the hospital's charges. In fact, a number of self-insured plans have chosen that option.

44. An employer's eventual cost of its health benefit plan will be affected, in part, by which method the employer selects to provide its hospital benefits. Selection of Blue Cross or an HMO will have different implications than selecting insured coverage from a commercial insurer. Selection of a self-insured plan which remits payments to the employee will have different implications than selection of a program which remits payments directly to the hospital.

Differentials In Other States

45. New York is not the only State which has differentials. Both Maryland and New Jersey have formal differentials set forth in statute or regulation. Like New York, these differentials are

due, at least in part, to insurers' activities in offering health insurance on an open enrollment basis.

46. The Maryland differential is 4% for open enrollment. See attached Exhibit "A" for a copy of the findings of the Maryland Health Services Cost Review Commission. (In particular, see pages 3, 4 and 15.) However, the Maryland statute requires open enrollment for only 30 days out of each year and the benefits in the policies are limited. In contrast, for open enrollment, New York requires that coverage be offered continuously throughout the year and the benefits covered under the policy offered are quite extensive. However, the clear parallel to New York is the Maryland linkage of the differential to insurer underwriting practices which spread insurance risk in a socially desirable fashion, and in contrast to the practices of other insurers which decline to undertake those practices.

47. New Jersey also has a statutory requirement of a differential in its hospital rate setting law. Attached as Exhibit "B" is a copy of a portion of the New Jersey statute. It expressly includes the broad provision of health insurance as a factor in establishing the differential. However, the differential in New Jersey is included in hospital rates in a very different fashion than New York rates.

48. Other States such as Pennsylvania have differentials which exist in practice because the State does not have a cost control statute for both Blue Cross as well as commercial insurers. In Pennsylvania the differential ranges from 18% to 30% depending upon the region, just as New York had during the 1970's prior to NYPHRM. The Blue Cross Plans in Pennsylvania offer extensive open enrollment and the community rated premiums for the policies are significantly less than the premiums offered by commercial insurers, even to persons who have passed medical underwriting in order to obtain coverage. However, again the clear parallel to New York is New Jersey's linkage of the differential to

insurer underwriting practices which spread insurance risk in a socially desirable fashion, and in contrast to the practices of other insurers which decline to undertake those practices.

Uniformity Among States

50. The fact that New York has a hospital cost control statute while other states do not, or other states have different statutes, should not result in a finding of preemption as to New York's differential, as argued by the Plaintiffs. The NYPHRM statute simply prescribes the rate a hospital shall charge to an insurer, the State's Medicaid program, or any other payor of hospital services. The amount of the State specified rate appears on the hospital bill which the hospital renders to the insurer or payor. On the portion of the hospital bill which lists the "amount due" the hospital simply substitutes the state specified rate in lieu of what would have been the hospital's own charges.

51. No two hospitals in New York State have the same reimbursement rate. Likewise, no two hospitals had the same schedule of charges prior to (or would have, subsequent to) the rate setting law. Similarly, hospitals in other states each have their own schedule of charges or, in some cases, a state mandated rate. There is no uniformity in hospital charges or rates which would exist even in the absence of New York legislation.

52. The important point is that there is nothing in New York's hospital cost control law which requires insurers or self-insured plans to operate their employee benefit programs in a different fashion from the manner in which they are operated outside of New York. The method a hospital uses to determine how much it will bill for services rendered may be different, but that is an obligation which falls upon the hospital.

53. The amount of the hospital bill in New York will be more or less than the amount of a hospital bill in Oklahoma, but that may

be true even if the state did not regulate hospital costs at all. It is also true of other expenses incurred in providing employee benefits such as the market rate for labor, taxes or highway tolls incurred in the course of work-related travel.

CONCLUSION

54. If successful, Plaintiffs' claims would destroy an important provision in the overall scheme for regulation of hospitals and health care costs in New York State. If Plaintiffs' arguments prevail in regard to the differentials as one component of the rates, then many other components of the rate setting scheme are at risk. New York's aggregate hospital financing scheme assures hospitals enough money to function to provide the quality and availability of hospital services which State officials deem appropriate. The integrity of that system would be severely compromised by a ruling that New York lacks the authority to set hospital rates. Yet the system also strictly limits the amount which insurers and other payors must pay for hospital care in order to assure that as many patients, businesses and governments that pay for hospital care can afford to do so, since their financial reserves are obviously limited.

55. No alternative mechanism is in place to deal with this contingency, and the dislocation which would result would, at a minimum, undermine all of the State's efforts at cost containment and the financing of all hospital care in the State of New York. The precise monetary loss cannot be predicted but would be substantial, particularly for the hospitals. These losses would eventually lead to increases in expenditures of all insurers and payors and in a greater tax burden on New York State citizens.

ARTHUR B. KLEIN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Jerry Weissman, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JERRY WEISSMAN, being duly sworn, deposes and says:

1. I am the Chief Financial Officer of Empire Blue Cross and Blue Shield (hereinafter "Empire"), a corporation organized under Article 43 of the Insurance Law. Empire is a member of the New York State Conference of Blue Cross and Blue Shield Plans (hereinafter the "Plans"). As such, I am familiar with the operation of Article 43 corporations, the health insurance system and the hospital reimbursement system in New York State and the factual issues in this litigation. I am also familiar with Empire's participation in the Government-Wide Service Benefit Plan (referred to by Blue Cross and Blue Shield organizations as the "Federal Employee Program") offered to federal enrollees pursuant to the Federal Employee Health Benefits Act. I make this Affidavit in opposition to Plaintiffs' Motions for Summary Judgment and in support of the Plans' and Empire's Cross-Motions for Summary Judgment.

2. Blue Cross and Blue Shield Plans in New York engage in a variety of practices which distinguish them from other types of insurers. For many years these differences have provided the Legislature with a reasonable basis for establishing different classes of payors under the State's hospital rate setting law. An

in-depth analysis of the historical basis of the differential is set forth in the Affidavit of Albert Antonini submitted herewith.

BACKGROUND INFORMATION

3. Empire provides health insurance coverage to more than eight million persons located primarily in New York City, the surrounding Metropolitan New York area, and Northeastern New York.

4. In 1991, Empire reimbursed approximately $2.5 billion to hospitals in New York State.

5. At the outset it should be noted that the differentials at issue only apply to inpatient hospital services. Due to an on-going shift from inpatient care to outpatient care over the past decade, inpatient hospital bills account for under 40% of the total health care services covered by the Plans. This figure is consistent with the figure offered by Aetna Life Insurance Company in the Affidavit of Burke, ¶7. Aetna states that 35% of Aetna's total costs are for inpatient hospital care. A *13%* advantage on only 40% of the total health care package translates into only a 5% competitive advantage in the total premium quote (13% x .4 = 5%).

6. It also should be noted that the increase in claims payments due to the increase in the differential from 13% to 24% for the commercial insurers of their claims payments need not require a corresponding increase in premiums or a reduction in benefits as alleged by the Plaintiffs. Most commercial insurers have substantial profit margins on insurance which could absorb—in whole or in part—the increased differential. Other insurers deliberately subsidize health insurance in order to sell more lucrative products such as life insurance. Therefore the costs will not automatically be passed along as increased costs to policyholders.

NEW YORK'S HOSPITAL REIMBURSEMENT SCHEME AFFECTS ALL INPATIENTS, NOT JUST ERISA PLANS

7. The Blue Cross and Blue Shield Plans provide health insurance coverage to a wide variety of groups and individuals.

8. For example, Empire Blue Cross and Blue Shield has a contract with the City of New York to provide health insurance coverage. At the present time, that coverage involves 372,000 contracts with city employees and retirees with premiums of more than $375 million per year.

9. In addition, Empire Blue Cross and Blue Shield and the other Blue Cross and Blue Shield Plans in New York State have a contract with the State of New York to provide hospital insurance. That coverage involves 450,000 contracts with State employees and retirees with premiums of more than $457 million per year.

10. Both the City of New York and the State of New York are governmental employers which are not subject to the provisions of ERISA.

11. On the other hand, Empire issues other large group contracts through employee benefit plans which are subject to ERISA.

12. Similarly, Empire's small group market is comprised of groups, some of which are regulated under ERISA and others that are not.

13. All of the New York State Blue Cross and Blue Shield Plans offer health insurance to persons who do not have employer health insurance and thus procure, and pay for, their own health insurance. For example, over 300,000 *persons* have direct payment (non-group) traditional insurance coverage (not counting

their spouses and dependents) with Empire. An additional 450,000 persons have Medicare Supplemental coverage.

14. None of those direct payment customers are subject to ERISA.

15. Other payors in the reimbursement system are not regulated by ERISA in any respect. For example, the State of New York and local county governments operate the Medicaid program, which provides publicly financed health benefits to millions of New York residents and receives the differential. The Medicaid program is not subject to ERISA. No-fault insurers are not regulated by ERISA, but do not receive the differential.

16. In summary, the NYPHRM hospital reimbursement system includes a broad array of payors that make payments to hospitals for rendering hospital services to a wide variety of persons covered by numerous types of programs and insurers. Some of those payors are governmental programs, some are insurers or HMOs, others are self-insured employers, and still others are programs such as volunteer firefighters or volunteer ambulance worker benefit plans.

17. The ERISA statute applies to some, but by no means all, of the employers, persons, or government agencies which ultimately pay hospital bills.

BLUE CROSS AND BLUE SHIELD PLANS ARE FUNDAMENTALLY DIFFERENT THAN COMMERCIAL INSURERS

18. The Blue Cross and Blue Shield Plans in New York State have a fundamentally different corporate mission than commercial insurers. That fundamentally different mission is the reason that the Blue Cross and Blue Shield Plans receive favorable treatment in the State's hospital rate setting statute.

19. Insurers such as the Plaintiffs in this action operate as ordinary, for-profit businesses. In most cases, the insurer collects premium income from employers and other customers and pays health care claims when they arise. Other insurers operate as mutual companies on behalf of their policyholders. Although they do not attempt to make profits as such, they attempt to provide economic benefit to their member policyholders by keeping their premiums as low as possible. In short, they provide a valuable service to their customers as a traditional insurance company, and similar to other insurance for homeowners, auto insurance, etc.

20. In contrast, Blue Cross and Blue Shield Plans are designed to undertake efforts to issue insurance to as many types of people and groups as is financially practical. For example, Empire's statement of corporate purposes calls for Empire to provide "the best possible coverage for the largest possible portion of the self-sustaining population on the most cost-effective basis." The Plans are not-for-profit. They have public representatives on the Board of Directors. They use different underwriting and premium setting methods than are employed by the commercial insurers. In short, Blue Cross and Blue Shield Plans have a corporate mission which is closely linked with State Legislative efforts to promote access to health insurance, which in turn has a significant impact on access to health care. For more details regarding the origin and purposes of Blue Cross and Blue Shield, see Exhibit A of the accompanying affidavit of Albert F. Antonini.

21. The different nature of Blue Cross and Blue Shield Plans is in part reflected in the fact that in New York, as well as most other states, the Legislature created different enabling legislation for Blue Cross and Blue Shield Plans than for other insurers. For example, Blue Cross and Blue Shield Plans are subject to prior approval of their rate increases by the Superintendent and public hearings during that rate approval process. (*See* Insurance Law §4308). Commercial insurers are not subject to either of these requirements.

22. Rochester is perhaps the most successful example of the unique role played by a Blue Cross and Blue Shield Plan in a community's intertwined health care and health insurance mechanism. Attached as Exhibit "C" is a New York Times article from August 25, 1992 which describes the impact Blue Cross has on access to health insurance and thus health care. Instead of simply performing the useful function of an insurer, the Blue Cross and Blue Shield Plans go a step beyond by acting as a catalyst to extend insurance to all segments of the community.

23. In summary, while commercial insurers and Blue Cross and Blue Shield Plans both perform the same basic insurance functions, they do so in fundamentally different ways. Based upon these differences, and to further underlying State policy objectives, the State has long treated Blue Cross and Blue Shield Plans in a different manner than commercial insurers, that different treatment has taken a variety of different forms (not just for hospital reimbursement).

THE DIFFERENT INSURANCE PRACTICES OF BLUE CROSS AND BLUE SHIELD

24. The two principal areas where the insurance practices of Blue Cross and Blue Shield Plans differ from those of commercial insurers are how they accept applications for insurance and how they set premiums for the coverage. Attached as Exhibit "D" is a report prepared by the Center for Health Policy Studies, a consulting firm in Maryland. The Report compares the insurance practices of Blue Cross and Blue Shield Plans with the practices of commercial insurers, including several of the Plaintiffs in this action, identifying significant differences between them.

25. The Plans offer community rated products meaning that premiums based upon the cost of providing health care benefits to a large pool of subscribers within a broad geographic region. The

resulting premium rate reflects the average cost and utilization of health care resources in the community as a whole, instead of the claims experience of a particular group or individual. Community rating makes premiums as affordable as possible to the greatest number of people by spreading risk over the entire pool of covered persons. This is considered good public policy because any group can be a good risk one year and a poor risk the next. So long as adequate numbers of groups with better than average experience are included in the pool to offset the groups with worse than average experience, the premiums can be set at an affordable level for all groups.

26. Empire has approximately 1.5 million small groups and direct pay (non-group) subscribers. The State-approved premiums for each kind of benefit are identical for all persons holding the same coverage, irrespective of their health or their actual need for covered services.

27. The Department of Insurance, in its regulation of the Plans over many decades, has required community rating and endorsed the valuable role that Blue Cross plays in providing such insurance. As the Superintendent of Insurance stated in a 1969 Opinion and Decision on subscriber rates, attached hereto as Exhibit "E".

> "Over the years, on of the basic tenets of Blue Cross has been the concept of "community rating"—the idea that health insurance rates should be the same regardless of whether a person is young or old, sick or healthy, where he lives or what his job is. The rates for Blue Cross should be based, under this theory, upon the experience of all subscribers, rather than having separate rates for such small classification or group depending upon the experience of that particular classification or group. *Many of the special statutory provisions for Blue Cross plans . . . were originally predicated upon the presumably unique*

community service role of Blue Cross, essential to which was community rating." (Ex. "E" at 14)(emphasis added).

28. Some Plans use community rating only for small groups consisting of from 3 to 49 employees, as well as individuals (who are referred to as direct pay subscribers) and individuals holding contracts to supplement their Medicare coverage. Other Plans, such as those in Rochester and Buffalo, use community rating even for most large groups. For example, in Rochester the Kodak Corporation pays the same premium rate as does a medium sized law firm or a small barbershop.

29. No community rating is offered by commercial insurers in New York. They often develop premiums based upon the expected claims experience of the particular group. In other cases the premiums may vary significantly based upon the age, sex and residence location of the persons insured. Premiums may rise dramatically if one or more persons in the group become ill.

30. The Plans engage in "open enrollment" which means that Empire and the other Plans offer coverage without requiring examinations or health statements as a condition of either issuing or renewing contracts. Instead, the Plans offer coverage to anyone who seeks it—good risk or poor risk. An applicant simply lists their name and address on the application, remits a check for the first premium payment, and the policy will be issued.

31. No open enrollment is presently offered by any commercial insurer in New York. In fact, commercial insurers deny coverage to many individuals and groups based on occupation, prior medical history and age. For example, the Jaymar Health Resource Book, a major tool written and used by commercial agents and brokers who sell health insurance policies to small groups, lists dozens of industries and occupations that are considered banned from commercial health insurance coverage. A sample of these

include manufacturers, air transportation companies, bars and cafes, construction companies, forestry, lumbering and logging, foundries, police officers, firefighters, oil and gas well companies, public schools, trucking companies and used car dealers.

32. Empire's periods of "open enrollment" have also been endorsed by the Superintendent. In a 1980 Opinion and Decision, attached hereto as Exhibit "F", the Superintendent of Insurance commented on the benefits of Blue Cross' open enrollment periods:

> *The availability of health insurance for all New Yorkers is of paramount importance to the Superintendent of Insurance.* Blue Cross/Blue Shield of Greater New York is commended for fulfilling its basic purpose of serving the needs of the community through its periods of open enrollment and, it is expected that the Plan will continue to serve this purpose by conducting similar periods of open enrollment in each of the coming years. Emphasis added. (Ex. "F" at 13).

33. In almost all cases, the Plans operate at a loss with respect to coverage of direct pay (non-group) persons. This includes Medicare supplemental coverage for the elderly. These policies are offered at a premium rate lower than the Plans' actual costs because this category of customers typically has difficulty affording the premium payments. Since the coverage is offered at a loss, the Plans price some of their other policies at a slightly higher rate.

34. In contrast, many commercial insurers do not even offer health insurance to direct pay (non-group) customers.

35. As a major part of its community rated business, Empire supplied Medicare Supplementary Coverage in 1991 to approximately 450,000 elderly New Yorkers. This coverage supplements

the benefits received from Medicare Part A (hospital) and Medicare Part B (medical), assisting Medicare recipients to pay the large Medicare deductibles and to fill other gaps in Medicare coverage. In 1987 to 1990, community rated Medicare supplemental losses amounted to almost $150 million statewide among the Plans.

36. In contrast, only a few commercial insurers (eight as of 1991) even provide this type of Medicare supplemental insurance in New York State. In fact, most of the named insurance company Plaintiffs in this action, such as Travelers Insurance Company and Aetna Life Insurance Company, do not offer these coverages.

37. The Blue Cross and Blue Shield Plans undertake insurance practices that a purely profit minded insurer would abandon in the heat of a competitive marketplace. The differentials assist the Plans in remaining competitive in the overall insurance marketplace and thereby maintain a sufficiently large base to support their community oriented coverage programs. Without such a base, the Plans would not be able to provide millions of New Yorkers with the type of affordable coverage desired by the Superintendent of Insurance and the Legislature. Those millions of New Yorkers who benefit from community rating—and in particular, the lower income, older and less healthy individuals who are able to remain self-sufficient by enrolling in Blue Cross, will be the losers if the differential is no longer available to the Plans.

38. Loss of the differential would result in a larger uninsured population in New York State. There is a correlation between the number of uninsured persons in a state and whether insurers in that State offer open enrollment for health insurance. States where insurers offer open enrollment have incidents of uninsurance that are twenty to thirty percent less than the national average. *See* the attached Exhibit "G" which contains portions of a national study which uses official Census Bureau and General

Accounting Office figures to report the number of uninsured persons in each State in relation to whether that State offers open enrollment. A summary based upon that data, which is also attached, demonstrates that the eleven States with open enrollment have 2.8 million fewer uninsured persons than the national average. New York, in particular, has 20.8% less uninsured persons than the national average. Many of the States listed also have differentials in hospital rates, as described in the accompanying Affidavit of Arthur B. Klein ¶¶ 45-48.

THE PLANS ENGAGE IN MANY PUBLIC HEALTH ACTIVITIES WHICH ARE DIFFERENT THAN OTHER INSURERS

39. The Plans also are different from commercial insurers due to the enormous financial stability the Plans give to hospitals and other providers. There are numerous programs in which the Plans participate which encourage cost containment and produce a quantifiable benefit to the community.

40. The Plans promote the financial stability of hospitals in two ways. First, the Blue Cross and Blue Shield Plans in the state provide hospitals with advance payments in anticipation of claims of some $300 million in the aggregate. This working capital advance is of extreme importance to the operations of the hospitals because it lessens the need of the hospitals to engage in expensive short term borrowing. Without it, the hospitals would be in immediate fiscal crisis. In contrast, commercial carriers pay hospitals long after patient care costs are incurred, and without providing any cash flow in the interim. There have been some estimates made that it takes commercial insurers 84 days to pay for inpatient hospital services for their insureds.

41. Secondly, by providing insurance to many tens of thousands of persons who otherwise would have no access to it, the Blue Cross and Blue Shield Plans substantially increase the num-

ber of patients for whose care hospitals receive full reimbursement, thus reducing the hospitals' bad debt and charity care problems.

42. The Plans have also exhibited a high degree of responsiveness to public policy initiatives. Empire was, for example, the only insurer to respond positively to requests for statewide fiscal intermediaries for the Department of Health's prenatal care demonstration project.

43. The Plans have enrolled over twenty-five thousand previously uninsured children in a new program called Child Health Plus which is administered by the State. Commercial insurers were invited to participate but declined even to submit proposals to be included in the program.

The Deterioration Of The Plans' Position In The Marketplace

44. Empire's community rating approach has made it vulnerable to the predatory risk selection criteria of the commercial carriers who offer health insurance *only* to the good risks, i.e., persons whose costs are less than the average reflected in the community rate. Those persons could obtain lower rates by leaving the community rated programs and obtaining coverage from other insurers who base premiums on a group's own favorable claims history.

45. The application of risk selection criteria employed by the commercial health insurance carriers to target and skim only the good risks from the Plans' community rated pools is commonly referred to as "cherry picking".

46. For example, certain commercial insurers seek only good risk groups and avoid or blacklist groups that are potential bad risks by selecting who they will insure based on health statements, physical examinations and tests, the exclusion of certain

industries, and other exclusionary factors such as age, sex, and geography.

47. Skimming or cherry-picking by certain commercial insurers of Empire's good risk groups has greatly accelerated since the late 1980's to the present. Over the last four years, Empire has lost more than 600,000 of its small group customers, roughly 47% of its small group pool. Ninety percent of these lost customers were good risks.

48. From 1988 through 1990, net contract losses in Empire's community rated small group pools averaged approximately 72,000 per year. During 1991, however, contract losses accelerated resulting in 90,000 contract losses, nearly 25% higher than the average annual loss of the previous three years.

49. Cherry-picking has had a dramatic impact on Empire's pools of community rated coverage. In 1986, the ratio of good risks to poor risks was 10:1. Currently the ratio is only 3:1 because of the commercial insurers' cherry picking.

50. Over the past several years, Empire has experienced a decline in enrollment of the groups under 50 persons. In 1988, the Plans had 1.8 million New Yorkers enrolled in small groups as compared to 1.2 million three years later. This decline has contributed greatly to the overall community losses which for Empire alone were $175 million in 1991. Coupled with this loss in enrollment has been a deterioration in the underwriting results produced by the remaining groups. For example, despite the decline in enrollment, total claims cost for the Plans on small groups increased by over 23%.

51. As the Superintendent himself has repeatedly noted, cherry picking by commercial health insurance carriers will eventually lead to the collapse of the community rated pools. As more of the good risks leave, resulting in a higher percentage of poor risks

submitting higher numbers of claims, premiums are driven up, which causes more good risks to leave with the result that premiums eventually will become too expensive for those left in the pool. *See* p. 11 of April 1, 1992 Decision, Exhibit "Q" to the Affidavit of Antonini.

52. Absent rate relief from the Superintendent, the 1992 underwriting loss sustained on Empire's community rated contracts is projected to be $270 million, plus an additional $850,000 loss on special programs offered to persons unable to afford health insurance, such as the special program for uninsured children. These losses would obviously be significantly higher if the benefit of the differential in payments for inpatient hospital services was no longer available.

1992 CHANGES IN THE DIFFERENTIAL

53. In order to ensure the Plans' ability to cover high risk residents in New York State, especially in light of the deterioration of the Plans' community rated pools, the Legislature increased the differential effective April 1, 1992 for commercial insurers from 13% to 24%. The 11% increase applies only to insured policies issued by commercial insurers; the 11% increase does not apply to any other insurers or payors subject to the 13% differential, such as no-fault auto insurers, workers' compensation programs, self-insured funds paying the hospitals directly, etc.

54. The differential rate component was increased for commercial insurers because the Legislature believed that the insurance underwriting practices of commercial insurers were disruptive to the insurance markets as well as an obstacle to the public's efforts to purchase health insurance. As explained and documented in the accompanying Affidavit of Albert F. Antonini, the Legislature had been debating an increase in the differential for some time. Although the Legislature eventually decided to divert the addi-

tional revenues from the extra 11% to the State Treasury, that does not change the underlying intent to increase the differential by an additional 11% for exactly the same reason that the basic 13% differential already existed. In adopting the 11%, the Legislature essentially was restoring the differential for commercial insurers to the 25% range which existed throughout the 1970's and early 1980's.

55. The increase in the differential is intended to help stop the cherry-picking. Community rated groups tempted to leave the Plans will now have to think twice as hard about that decision, because the differential advantage they would be giving up by abandoning the community insurance pool would be much more (24% instead of 13%). *See* remarks of Superintendent of Insurance Curiale set forth in Exhibits "O" and "P" of accompanying Affidavit of Albert F. Antonini.

56. The Plaintiffs are well aware that the differential is favorable treatment offered to the Plans to offset the increased costs inherent in their open enrollment and community rating insurance practices. On March 5, 1992, at a public hearing convened by the State Senate Committee on Insurance to discuss legislation regarding community rating, testimony was offered by Chris Peterson, a senior counsel for Plaintiff Health Insurance Association of America. Mr. Peterson stated "they [Blue Cross] were granted 13 percent to pay for the cost of open enrollment and community rating." *See* attached Exhibit "H". While the remaining portions of the debate revolved around whether the 13% should be increased or decreased, it is clear that Plaintiffs acknowledge that the favorable treatment offered to Blue Cross in the hospital rate setting system is recognition of the Plans' insurance practices such as community rating and open enrollment.

HMO DIFFERENTIAL

58. That the Plans "earn" the differentials by engaging in activities not engaged in by other insurers is illustrated by the enactment of a differential in 1992 for HMOs. Since HMOs began in this State they have been afforded the same favorable treatment as the Plans. This is due in part to the fact that the first HMOs in the State (such as HIP-Health Insurance Plan of Greater New York) were created as not-for-profit corporations under Article 43 of the Insurance Law, just like Blue Cross.

59. Furthermore, HMOs were expected to enroll applicants without an underwriting process or excluding pre-existing conditions, and to price their coverage using community rates rather than the claims experience of the particular employer. *See* 10 NYCRR, Part 98.6(1).

60. Over the past few years some HMOs failed to live up to those requirements and incurred the wrath of regulatory officials who claimed that not all HMOs were performing the public service type insurance enrollment activities which were the basis for offering favorable treatment to HMOs in the hospital cost control statute. For example, see statements of Superintendent of Insurance Curiale at public hearings urging legislation requiring HMOs to perform open enrollment insurance activities. *See* Exhibit "P" to Affidavit of Albert F. Antonini, pages 11 and 14. In fact, the Legislature did enact such a requirement in July 1992. *See* Amendments to §4406 of the Public Health Law, at ¶17 of Chapter 501 of the Laws of 1992.

61. As referred to above, the Health Department regulations require HMOs to provide a variety of community services, including efforts to enroll Medicaid patients in insured HMO coverage where the State pays a fixed insurance premium rate to the HMO. For many years a controversy has existed between the

State and some HMOs regarding whether some HMOs were executing such contracts at a reasonable pace.

63. In April of 1992 the State adopted legislation which took part of the differential away from the HMOs (9%) and permitted the HMOs to recapture the full differential if the individual HMO had indeed entered into insured premium arrangements with the State and enrolled targeted numbers of Medicaid patients into those insured arrangements. Like the additional 11% differential on commercial insurers due to their discriminatory underwriting practices, the money from the new 9% differential on HMOs was diverted to the State General Fund, rather than the traditional hospital recipients of the differential monies. However, the diversion of receipt of those funds to the State Treasury does not change the purpose of the underlying HMO 9% differential, which was to encourage HMOs to expand their offering of insured coverage to include persons enrolled in the State's Medicaid program. The new HMO 9% differential is thus just like the other differential because it is designed as a "carrot" or incentive for an insurer (in this case an HMO) to undertake expanded insurance enrollment activities.

63. It should be noted that the new HMO 9% differential affects Blue Cross and Blue Shield as well. The Plans operate five different HMOs in New York State. The HMO operated by Blue Cross and Blue Shield of the Rochester offers extensive insured HMO coverage to the Medicaid population and qualifies for a full waiver of the 9%. The four HMOs operated by the other Blue Cross and Blue Shield Plans, including Empire Blue Cross and Blue Shield, are not extensively enough engaged in providing insured coverage to the Medicaid population to qualify for a waiver and thus will now pay an additional 9% on hospital inpatient reimbursement rates.

EMPIRE'S PARTICIPATION IN THE FEDERAL EMPLOYEE PROGRAM

64. The United States Office of Personnel Management ("OPM") contracts with several carriers which offer experience-rated health insurance plans and health maintenance organization benefit plans to federal enrollees under the Federal Employees Health Benefits Program. 5 U.S.C. §8903; 48 C.F.R. §1601.101(b). Some of the experience-rated plans are underwritten by Blue Cross and Blue Shield organizations and some by commercial health insurance companies.

65. Empire Blue Cross and Blue Shield provides benefits in its service area to federal enrollees through its participation as an underwriter of the Government-Wide Service Benefit Plan. The Government-Wide Service Benefit Plan is an experience-rated health insurance plan. 48 C.F.R. §1615.802.

66. The carriers for the experience-rated Federal Employees Health Benefits Program plans receive premium income, pay the expenses of the plans (including claims expenses, administrative expenses, taxes, etc.) from the premium income, account to the government for the resulting excess or deficit, and hold an excess for the benefit of the plan in future years. Carriers are liable for the claims of their enrollees if the premium income and the government's contingency reserve are insufficient to pay claims. 48 C.F.R. §1602.170-6; 48 C.F.R. §1615.905; 48 C.F.R. §1616.102(b).

67. The enrollment charges for the Federal Employees Health Benefit Program plans are the sum of the carriers' premiums and additional charges by the OPM. Annually, the carriers and OPM agree on premium rates, a 4% factor is added to the premium rates, and the sums of those amounts (total enrollment charges) are collected by deduction from federal employees' pay and from annuitants (approximately 40%) and contributions from federal

payroll offices and the OPM for annuitants (approximately 60%). 5 C.F.R. §890.502.

68. The enrollment charges for the Federal Employees Health Benefits Program plans are paid to the Employees Health Benefits Fund; 1/104 of the enrollment charge is credited to OPM's administrative reserve, 3/104 is credited to OPM's contingency reserve, and 100/104 is made available to the carrier through a letter of credit account in the United States Treasury. 48 C.F.R. §1602.170-9; 5 C.F.R. §890.503. In addition, amounts are made available intermittently from OPM's contingency reserve to the letter of credit accounts. 5 U.S.C. §890.505; 48 C.F.R. §1652.216-71; 48 C.F.R. §1652.232-70. The letter of credit is irrevocable (the equivalent of cash) for the payment of benefits under the health benefits plans. 31 C.F.R. §205.5. OPM requires carriers to account for all amounts made available from the Employees Health Benefits Fund to the carriers' letter of credit accounts as premium income.

69. The carriers of the experience-rated plans are required to account for the income and expenses of the plans. 48 C.F.R. §1652.216-71. Carriers' allowable charges to the contracts are determined by the Federal Acquisition Regulation as implemented by the Federal Employees Health Benefits Acquisition Regulation. 48 C.F.R. Ch. 1; 48 C.F.R. Ch. 16. In general, carriers are permitted to charge State and local taxes to their experience-rated contracts as administrative expenses. 48 C.F.R. §31.205-41. Prior to 1992, however, carriers were required to report State premium taxes separately as "other charges". 48 C.F.R. §1652.216-71. At least one Blue Cross and Blue Shield organization that was subject to a State tax for assessment measured by the number of its enrollees participating in the Government-Wide Service Benefit Plan reported those taxes to OPM prior to 1992 as premium taxes.

70. The Federal Employees Health Benefits Act was amended, effective January 1, 1992, to preempt certain State taxes relating to payments to carriers from the Employees Health Benefit Fund. Public Law 101-508, §7002(c), 104 Stat. 1388; 5 U.S.C. §8909(f)(1). OPM implemented that change in law by amending the Federal Employees Health Benefits Acquisition Regulation to provide that carriers cannot charge taxes measured by premiums to their experience-rated contracts after 1991. 48 C.F.R. §1631.305-41.

71. Subsequently, OPM considered whether the differentials in hospital reimbursement rates are preempted by 5 U.S.C. §8909(f)(1). In a letter dated August 25, 1992, OPM advised the Superintendent of Insurance for the State of New York that §8909(f)(1) preempts the 11% differential and the 9% differential with respect to HMOs. A copy of the OPM's letter dated August 25, 1992, is attached as Exhibit "I".

72. The operation of the differentials in hospital reimbursement rates is wholly unrelated to the amount of premiums paid by federal enrollees or even the number of enrollees. In fact, the insurance companies and third party administrators of health benefits plans are not required to account for or report the amounts of their insurance premiums and enrollees in the State of New York to hospitals in the State of New York.

CONCLUSION

73. Over the decades since the development of the Blue Cross and Blue Shield movement, the Plans in New York State have continually been accepting the social responsibility of providing health insurance to the broadest spectrum of New Yorkers. Going well beyond offering health insurance as a necessary business commodity, the Plans undertake a public policy mission to offer health insurance to as many persons as is practical. Many of those persons could not obtain coverage at all from other insurers; other

persons would be offered coverage but, as a result of the premium setting methodology utilized by other insurers, could not afford it. In addition, the Plans offer substantial cash flow assistance to hospitals which other insurers do not.

74. Based on the substantial differences between types of insurers, when the Legislature created a hospital cost control law it offered different hospital rates to Blue Cross in light of Blue Cross' different health care and health insurance practices. There was no intent to provide undue favoritism to Blue Cross or to be punitive towards other payors. The reasonable differentials in hospital rates simply reflect the Legislature's evaluation of the magnitude of the differences between the Blue Cross and Blue Shield Plans and the financial advantage in hospital rates which the Blue Cross and Blue Shield Plans need in order to attain the goals the Legislature has established.

JERRY WEISSMAN

[Jurat ommitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Albert F. Antonini, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

ALBERT F. ANTONINI, being duly sworn, deposes and says:

1. I am the President and Chief Executive Officer of Blue Cross and Blue Shield of Central New York, Inc. which is a member of the New York State Conference of Blue Cross and Blue Shield Plans. I presently serve as Chairman of the Conference of Plans.

2. I have been employed by Blue Cross and Blue Shield of Central New York (and its predecessor corporations) since 1954 and have been President of the corporation since 1982. I am fully familiar with the operation of the hospital reimbursement system and the operation of the health insurance system in New York State. In particular, I am familiar with the differential in hospital reimbursement rates challenged by the Plaintiffs in these actions and its historical role in the State's regulation of insurance. I execute this Affidavit in support of the Plans' and Empire's Cross-Motion for Summary Judgment on the basis that the laws creating the differentials are not preempted by ERISA.

A. THE PLANS

3. The Conference of Plans is an unincorporated association consisting of all six Blue Cross and Blue Shield Plans which operate as Article 43 corporations in New York State.

4. The Plans are: Empire Blue Cross and Blue Shield, Blue Cross and Blue Shield of Utica-Watertown, Inc.; Blue Cross and Blue Shield of Central New York, Inc.; Blue Cross and Blue Shield of the Rochester Area, Inc.; Blue Cross of Western New York; and Wholehealth Insurance Network, Inc. (d/b/a Blue Shield of Western New York and Blue Shield of Northeastern New York).

5. The Plans are not-for-profit health service corporations, organized and operating pursuant to Article 43 of the Insurance Law. The Plans provide coverage for hospital and health-related services to more than 12 million subscribers, with Empire Blue Cross and Blue Shield alone providing coverage to more than eight million subscribers. The Plans contract with hospitals to provide covered hospital services under the terms of applicable subscriber contracts and pay the hospitals for such services at rates set by the New York State Commissioner of Health. The hospitals, in turn, must accept the reimbursement as payment in full for these services provided to the Plans' subscribers.

6. As not for profit health services corporations, the Plans are subject to extensive regulation and oversight by the Superintendent of Insurance of the State of New York (hereinafter "Superintendent"). The Superintendent's regulatory authority over the Plans includes broad audit powers (Ins. L. §309), approval of the contracts with subscribers (Ins. L. §4308), prior approval of premium rates for all such subscriber contracts after a public hearing process (Ins. L. §4308), oversight and responsibility for the Plans' maintenance, and restoration of required statutory reserve levels (Ins. L. §4310), enforcement of the

statutory limitations on expenses (Ins. L. §4309) and permissible investments (Ins. L. §4310). This is a more extensive regulation than applied to the commercial insurers.

B. THE DIFFERENTIAL IS DESIGNED TO REGULATE INSURERS

7. While the differential is set forth in the Public Health Law, it is nevertheless a tool of State regulation of insurers and the business of health insurance. In fact, State policy regarding public health and health insurance are intricately intertwined. No other type of insurance (such as life insurance or property and casualty insurance) is as interrelated with the discipline or subject matter which it is providing insurance for, as is health insurance. That unusually tight relationship between public health and health insurance accounts for the fact that statutes, studies and discussions of the differential mention public health at the same time as they mention insurance, or do not always clearly delineate between them.

8. The concept of the differential and its purpose is actually quite simple. Commercial insurers obtain a competitive advantage in the health insurance markets when they are able to carefully select the persons they will insure by excluding persons who are ill, excluding industries where people are likely to become ill or excluding persons, through risk factors such as age and sex, otherwise at high risk for illness or disease. Thus, commercial insurers obtain a significant competitive advantage in the health insurance markets by insuring only good risks. In contrast, the Blue Cross Plans offer policies to anyone who applies (called open enrollment) and set premiums for many policies by charging the same amount to all customers, without price adjustments based on age or sex or their history of claims (called community rating). These and other practices are always good public policy but not always good business practices in a competitive marketplace.

9. The differential operates in the following manner: Suppose a Blue Cross Plan and a commercial insurer each insure 1,000 people per year. And also assume that if you took 1,000 people at random from New York State, their total hospital bills for a year would be $1,000,000. This means that the average cost of hospital care is $1,000 per person.

10. If, however, you carefully selected 1,000 persons who are healthy and issued coverage only to them, their total hospital bills for a year would be significantly less, assume $769,000.00. This means that the average cost of a healthy person is $769 per year.

11. The insurer that carefully selects the persons it will accept obtains a competitive advantage (its cost is $769 per person). The insurer which accepts every applicant has a higher price (premium of $1,000 per person) and will be under competitive pressure to abandon its practice of accepting all applicants in order to match the lower prices of its competitors for the good risks.

12. However, if the insurer that accepts every application now decides to discontinue that practice in order to stay competitive with the other insurer, many persons who are ill would no longer be able to obtain health insurance. They will either have to go without any health insurance (which is impractical since they are ill and will need to pay for their care) or if they are poor or become poor as a result of their expenditure for health care, they will become eligible for the State's Medicaid program (which is a taxpayer financed program). From the Legislature's perspective, both of these options are unacceptable.

13. The differential is the State's mechanism to attempt to level the competitive marketplace to accommodate the desired public policy practices of other insurers, such as the Plans who accept all applicants for coverage. The differential attempts to offset the competitive advantage which commercial insurers obtain by requiring commercial insurers to pay more to hospitals. In an effort

to balance out the insurance marketplace, the differential requires commercial insurers pay more for inpatient hospital care, and thus the premium rates charged by commercial insurers are closer to the premium rates charged by the Plans, whose premiums are higher because they insure individuals and groups who utilize greater health care services.

C. HISTORICAL USE OF DIFFERENTIAL TO REGULATE INSURANCE MARKETS

14. The public policy basis for the differential is well documented and is the subject of many reports and investigations spanning decades. Written references to the differential as necessary to facilitate the different practices of not-for-profit insurers as compared to commercial insurers can be traced from 1958 to the present.

The Trussell Report

15. In 1958, Governor Rockefeller commissioned a report regarding the public health and insurance questions then facing the State. A Columbia University Professor named Raymond Trussell was selected to produce the report which was entitled, "Prepayment for Hospital Care in New York State", portions of which are attached hereto as Exhibit "A".

16. Significantly, the starting point for the discussions of the public health and insurance issues presented was a discussion of the development of Blue Cross and Blue Shield Plans and notes the distinction between the services and purpose of Blue Cross and Blue Shield Plans as not-for-profit health insurers compared to the activities of commercial insurers. The report stated that the distinction began in New York State in the 1930s when separate statutes were enacted for Blue Cross and Blue Shield regulation as opposed to those of traditional commercial insurers. The historical summary noted, on page 16, that the fundamental concept

of Blue Cross is to spread the risk to the greatest extent possible. The Trussell report also noted that given the difference in the intent to create not-for-profit health service plans such as Blue Cross and Blue Shield in contrast to those of commercial insurers, the Plans have different privileges and obligations within the State regulatory scheme.

17. In the text of the report it noted the beginnings of the opportunity for "cherry-picking", which is the marketing practice of an insurer which only seeks new customers whose medical costs are lower than average, and rejects or avoids potential customers whose medical costs are above the average. On page 44, the report concluded that:

> as a general observation it may be said that, while ideally the Blue Cross Plans should accept any person who presents himself for membership, the Plans find that unrestricted enrollment tends to add persons in relatively poor health without the compensating balance of persons whose health is relatively good. If we could assume that Blue Cross had a representative cross-section of the community, unrestricted enrollment might be a possibility. As it is, [other] insurance companies through experience rating, select out of the community many of the groups whose members are in relatively good health. The Blue Cross Plans, therefore, denied the possibility of compensating for the very worst health risks with coverage for the very best, must either restrict enrollment for everyone or raise rates for everyone. Blue Cross has limitations imposed by the competitive environment in which it finds itself. If public policy requires an unrestricted right for everyone to join Blue Cross, a means must be found to supplement Blue Cross income by public subsidy or by requiring all health insurance carriers to charge premiums calculated on level lifetime premium based on actuarial lifetime utilization projection.

18. The Trussell report, issued over thirty years ago, lays out the same public policy framework for providing advantages to certain insurers in the marketplace, such as the Plans, which engage in activities directed toward fulfilling public goals. The public policy goals and the efforts to reach those goals have not changed since that time.

19. In discussing rising hospital costs and the impact which those costs have on premiums for health insurance, the Trussell report concluded that if the not-for-profit health insurance concept was to survive, Blue Cross costs could be reduced by taking only the "low risk" groups for membership in Blue Cross, which would reduce the costs to the Plan. However the report noted that "Blue Cross is intended to serve the entire community, not just those who need less hospitalization."

20. In the 1950s, the State did not have a State-imposed hospital cost control system. Instead Blue Cross Plans negotiated with hospitals to obtain discounts or agreed-upon reimbursement methodologies, which the Blue Cross Plan would pay instead of the hospitals' own established charges. In reviewing these various methodologies, the Trussell Report noted that when negotiating discounts the first major negotiable item is the amount of the discount to be given and that the discount (another word for the differential) represents a recognition of the community concept and purpose of the Blue Cross Plan. Thus, the Trussell report set forth the first written acknowledgment of the correlation between the fact that Blue Cross Plans pay hospitals less than other payors pay, and the fact that it is Blue Cross' public service activities which entitle it to that discount.

The Folsom Report

21. Several years after the Trussell Report, the Governor created a Committee on Hospital Costs chaired by Marion Folsom. This Committee issued a report in 1965 which primarily focused

its attention on hospital cost control issues. However, the "Report of the Governor's Committee on Hospital Costs", portions of which are attached as Exhibit "B", noted the fact that Blue Cross Plans were moving from community rating to experience rating which commercial insurers traditionally utilized. *See* Exhibit "B" at pp. 58 and 59. The report noted that the reason why Blue Cross Plans were motivated to implement experience rating was in order to compete with insurance companies which did not practice community rating. *See* Exhibit "B" at p. 59. The Folsom report concluded that it was vital to the community interest to share the costs of those persons who need large amounts of hospital care, not step back from that long-standing position. The report stated that the Plans best serve the community needs when they maintain the broadest possible risk-sharing. The community and hospitals in turn have given the Plans advantages (payment of lower hospital rates, and a tax exemption) so that they could continue those policies to the community as a whole. The report went on to say that a system that "gravitates toward serving favorable risks, and leaves unreined the excess costs to high users, is not meeting this social need."

22. The report urged Blue Cross Plans to reconsider moves away from community rating and broad risk-sharing and recommended that rather than resorting to experience rating Blue Cross seek aid for such high-cost groups from public funds. While access to public funds was not any more feasible in the 1960s than it is in the 1990s, the Folsom report clearly establishes the link between the preferential hospital reimbursement treatment which Blue Cross receives with the community service activities which Blue Cross performs by insuring high-risk subscribers that other insurers do not.

The Move Towards An All-Payor Reimbursement Method

23. As health care costs continued to rise in the 1970s, the State's decision to regulate inpatient hospital rates only for the

publicly financed Medicaid program, for Blue Cross and Blue Shield and HMOs was questioned. Costs were rising for commercial insurers, workers compensation, no-fault auto insurers, ambulance and Fire Department volunteers and self-insured plans as well. Furthermore, there was a general feeling that an effective and equitable hospital cost control system would have to regulate revenues from all payors. *See* discussion of hospital reimbursement schemes in New York set forth in the Affidavit of Arthur B. Klein submitted herewith. To begin to address this problem the Legislature created the Council on Health-Care Financing. The Chair and Vice Chair of the Council were the chairs of the Senate and Assembly Health Committees, and the members were persons prominent in the hospital and insurance fields. The Council continues today and almost all major hospital reimbursement legislation since 1978 has emanated from the Council's activities.

24. In previous years, there was a differential, but it was not set forth in statute. From the 1940s until 1982, commercial insurers paid the hospital's charges. Blue Cross paid either an amount negotiated with the hospital (until 1969) or a rate set pursuant to the State's original hospital cost control statutes (from 1970 through 1982). The difference between the regulated hospital rate paid by Blue Cross and the (essentially) unregulated hospital charges paid by commercial insurers was "the differential." During this period, the de facto differential ranged from 25% to 40%, although it varied by hospital and was greater in some regions of the State than other regions. As the Council on Health-Care Financing grappled with the many issues involved in developing a more comprehensive system, the differential was one of the most controversial issues the Council faced.

25. Council staff produced a paper regarding the differential, a copy of which is attached as Exhibit "C". On pages 9 and 10, the Council articulated that the differential is due to the different types of customers each insurer accepts, and the desirable impact

of Blue Cross' activities on the New York State community as a whole.

26. In 1980, the Council issued its first major report on establishment of a comprehensive hospital rate-setting system entitled "Recommendations for Financing Hospital Inpatient Care", portions of which are attached hereto as Exhibit "D". At principle 6 of the report, the Council acknowledged that "a prime consideration in establishing a payment differential is to reflect economic advantages or disadvantages and social considerations generated by differing operational policies and practices [of insurers]. *See* Exhibit "D" at pp. 92 and 93.

The First SHRPC Komaroff Report

27. In 1983, the State's first legislation affecting all insurers and payors of hospital care took effect. The system is referred to as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). NYPHRM included a differential specified in statute for the first time. The differential ranged from 12% to 15%, depending on what the differential was previously at each hospital. In addition, the new statute called for a review of the appropriateness of the differential.

28. The differential was studied by the State Hospital Review and Planning Council ("the SHRPC"), which is the body designated in the Public Health Law to adopt hospital reimbursement regulations, as well as regulations governing quality of care in hospitals and the public need for identical hospital facilities. The SHRPC's review was chaired by Stanley Komaroff, Esq., (the first Komaroff Committee). A copy of this first Komaroff Report is attached as Exhibit "E".

29. The Komaroff Committee requested and received position papers from interested parties. Interested parties submitting position papers included Plaintiff Health Insurance Association of

America, the Blue Cross and Blue Shield Plans, the State Insurance Department, individual insurance companies and self-insured plans. It is noteworthy that no individual hospital, or any of the regional or Statewide hospital associations, appeared at Committee meetings to submit arguments regarding the differential, and the debate was therefore conducted among insurers and about insurance.

30. A brief but eloquent statement of what the differential is about was provided by Dr. Saward, a member of the Komaroff Committee. His two-page letter to other members of the Committee dated April 22, 1985 is attached as Exhibit "F". Dr. Saward was from Rochester which has long been a bastion of community rating and open enrollment. Out of the hundreds of documents available regarding deliberations over the purpose and appropriate size of the differential, Dr. Saward concisely noted that the purpose of the differential is to promote insurance coverage to the maximum proportion of the population, and that the differential (and indeed even the insurers themselves) is simply the tool of State policy to attain that goal.

31. The first Komaroff report in 1985 was guided by five principles set forth on pages 3-4 as follows:

1. Hospital charge differentials, at least within New York State, should continue to be appropriate means to enable the State to achieve certain social policy objectives, including providing hospitals with certain levels of working capital and encouraging the availability of substantial and affordable health insurance for its citizens, regardless of health status or insurability.

2. Differentials should be structured to encourage payors to (a) provide insurance protection, and prac-

tices which meet social policy objectives and (b) promote hospital cost savings.

3. Although the degree of any differential shall be based on all relevant factors, both objective and subjective, no specific mathematical formula is possible; the basis of the differential is not currently susceptible of precise quantification, and historically has not been so.

4. Recommendations for change should be conservative, i.e., cautious and gradual, in recognition of the fragility of the healthcare financing reimbursement system.

5. Payor equity should not be achieved at the expense of provider inequity.

32. After establishing broad access to insurance as a principle of the review, the Report went on to conclude (on page 6) that:

> With respect to coverage practices, Blue Cross/Blue Shield is the exclusive dominant factor in the health industry in three important categories, for which the Committee believes a differential is warranted. First, Blue Cross provides individual (direct pay policies) and small group policies, without medical underwriting and at state-approved community rated premiums (meaning premiums that are not age or sex rated nor based on the level of health risk). Second, it provides Medicare supplemental insurance to more than 1 million people in its community rated pool. Thirdly, it provides insurance coverage to more than 5 million people at community-based rates pursuant to which it is able to attract sufficient numbers of healthy, low risk subscribers at attractive prices. In effect, these low risk subscribers subsidize a higher-than-

average claims cost of the high risk in this community rated pool.

33. The Komaroff Committee believed that Blue Cross' community rating practices were achieving key social policy objectives of making insurance coverage available in situations where other insurers did not, and providing subsidized insurance coverage for vulnerable groups such as the elderly, and that some significant differential was necessary for Blue Cross to maintain its then current ratio of low risk subscribers compared to high risk subscribers.

34. Perhaps the best evidence of the differential as a tool to regulate insurance is found in the recommendations of the Committee. *See* Exhibit "E", Recommendation 1 on page 8 and Implementation Issue 6 on page 12. The first recommendation was that if the differential was to remain at its level of 13%, the Blue Cross Plans should expand their community service activities. The Committee also recommended that individual commercial insurers be permitted to obtain lower differentials by engaging in the types of community service insurance activities which the State desired, and which to date only Blue Cross engaged in. *See* Exhibit "E", Implementation Issue #5 on Page 12. Thus, the Committee was using the differential as an incentive to encourage both Blue Cross and insurers to engage in more public policy oriented insurance activities.

35. The Committee concluded its report by noting that the thrust of its remarks coincided with the work of the Subcommittee on Insurance of the Legislature's Council on Health Care Financing regarding the use of hospital financing mechanisms to achieve health insurance goals. *See* Exhibit "E", Implementation Issue 7 on page 13.

Measurement Of Insurer Activities To Obtain The Differential

36. In 1988, the Legislature enacted revised hospital reimbursement legislation. As a part of that legislation, the Legislature established the differential at 13% for all hospitals' rates, but included provisions allowing the differential to fluctuate based on the insurers' own activities, as recommended by the first Komaroff Committee. *See* Public Health Law § 2807-c(11)(i) as set forth for 1988-1990 in the attached Exhibit "G". In fact, under the 1988 legislation, the differential for all Article 43 corporations such as Blue Cross would decrease from 13% to 11% if the Blue Cross Plan did not offer hospital and medical insurance on an open enrollment basis continually throughout the year. In response, at least one Blue Cross Plan expanded its open enrollment activities from 30 days per year to year-round in response to the more demanding standards set forth in the new legislation.

37. A second provision stated that an individual commercial insurer could obtain an 11% differential for itself (while other commercial insurers and other payors continued to pay a 13% differential) if that commercial insurer offered open enrollment for hospital and medical insurance.

38. The law stated that the determination of whether insurers met the requirements would be made by the Superintendent of Insurance. The same legislation required the Superintendent to establish standards and criteria for measuring insurer performance to determine whether the differential should be adjusted. *See* page 46 in attached Exhibit "G", which added a new § 335 to the Insurance Law.

39. The Insurance Department promulgated a regulation (11 NYCRR Part 42) to implement the new statute. Periodically the Superintendent requested that the affected insurers document their entitlement to the differential. Attached as Exhibit "H" is a copy of a sample letter sent by the Superintendent to insurers.

Also attached is a typical response submitted by the Blue Cross and Blue Shield Plans to document that they provide the community service types of insurance which the Superintendent of Insurance requires to qualify for the differential.

40. The Superintendent also issued a report to the legislature regarding insurer compliance, as required by the new law. A copy is attached as Exhibit "I". The report notes on page 3 that no commercial insurer responded to the initiative to stimulate insurers to offer open enrollment. The report also found that all of the Blue Cross Plans were in compliance, although opportunities for improvement such as broader advertising of community rating, were identified and agreed to by the insurers.

Statutes Regarding Reviews of the Differential

41. The same legislation which established the statutory requirements of formal reviews of insurer activities by the Superintendent required additional reviews of the differential itself. Unlike the 1982 statute which required the first Komaroff report, this statute was more explicit in its references to the differential in regard to State regulation of insurance. The Legislation directed the State Hospital Review and Planning Council (of which the Komaroff Committee was a part) to conduct its review in conjunction with the Subcommittee on Insurance of the Legislature's Council on Health-Care Financing. Furthermore, the new statute specifically called for the Subcommittee on Insurance to review the differential "with respect to, among other factors, the availability of health insurance . . ." The statutes are attached as Exhibit "J".

42. The 1988 statute made it clear that the differential's purpose was to regulate insurers and insurer activities in the health insurance markets. First, the 1988 statute was structured to provide incentives to both Blue Cross and commercial insurers to obtain a greater or lesser differential by undertaking specified

insurance enrollment activities designed to create broader access to health insurance. Secondly, the statute called for two reviews of the differential—both of which referred to the role of the differential in health insurance.

The Second SHRPC Komaroff Report

43. The Komaroff Committee was reconvened to conduct the State Hospital Review and Planning Council's second review of the differential. As occurred during the first review, the principal parties to the deliberations were commercial insurers, Blue Cross and Blue Shield Plans, the State Insurance Department and other payors of hospital bills.

44. The second Komaroff Committee report, a copy is attached as Exhibit "K", was issued in 1989.

45. The Committee's recommendation regarding the differential began by stating that:

> No concrete, absolute or precise information regarding the value of the differential is available, except of course in the area of prepayment. Although this is somewhat frustrating, it is not surprising since the differential is an indirect stimulus—not a direct stimulus—to fulfillment of various goals. Nevertheless, by a strong consensus, the Committee recommends that the existing differential should be continued in 1991 and for a reasonable period beyond that, unchanged in amount. The Committee believes that the differential provides some form of leverage in encouraging payors and hospital providers to engage in activities which accomplish public policy objectives. Based on our understandings, changes could further destabilize a hospital system already in considerable financial distress and therefore threaten the maintenance of quality patient care.

46. Most importantly, the recommendations acknowledged that the differential provides legislators and regulators with "some form of leverage" over insurers to encourage them "to engage in activities which accomplish public policy objectives." This is an explicit statement that the State uses the differential to control the insurers' business activities—which is the essence of a State's regulatory scheme for the insurance business.

The Report of the Subcommittee on Insurance

47. Later in 1989 the Subcommittee on Insurance of the Legislature's Council on Health Care Financing issued their report regarding the differential. Since the two reports were prepared in cooperation with each other, they recite the history of the differential and the policy analysis in a similar fashion. The Subcommittee on Insurance recommended that future use of the differential, and the level or amount of the differential, be guided by the following principles:

(a) The differential has served as a useful vehicle to promote social policy objectives, especially access to broad and affordable health care coverage, and should continue to be used as a vehicle—although not an exclusive vehicle—to achieve such objectives.

(b) The differential should be structured to encourage payors to adopt practices which broaden insurance coverage, and which promote hospital cost savings.

See Subcommittee Report at p. 5. A copy of the Report is attached as Exhibit "L".

48. The Subcommittee on Insurance concluded that the differential should be continued, in part because "the differential does provide leverage in encouraging payors and hospital providers to

engage in activities which accomplish public policy objectives." *See* Exhibit "L" at p. 6.

The Gottfried Insurance Underwriting Bill

49. In 1991, Assemblyman Richard N. Gottfried introduced a bill to increase the differential, but not on an across-the-board basis. The bill provided that the differential would be increased only for certain insurers which engaged in particular insurance underwriting practices which the Legislature desired to discourage. Specifically, the bill required insurers that utilized physical exams, laboratory or screening tests, such as for the HIV virus, to pay an extra 6% in their hospital reimbursement rates. Similarly, insurers which utilized industry or occupational classifications to determine premium rates or eligibility for coverage would also pay an extra 6% in their hospital reimbursement rates. A copy of the bill and explanatory material are attached as Exhibit "M".

50. The bill was subject to considerable debate but was not brought to a vote. Evidence of the underlying debate regarding the contrasting practices of commercial insurers and Blue Cross and Blue Shield Plans is displayed in the memoranda each party submitted to the Legislature regarding the bill. *See* Exhibit "M". This includes memorandum submitted by the Blue Cross and Blue Shield Plans documenting the number of customers they had lost due to the alleged "cherry-picking" by commercial insurers.

51. The bill is a clear example of further efforts to construct the hospital rate setting system in a fashion designed to induce insurers into abandoning objectionable practices or, in the alternative, compromising the financial advantages the insurer obtains from those objectionable practices and attempting to compensate for those practices.

52. The bill proposed that the funds from the underwriting allowance be used in the bad debt and charity care system already

in existence to help hospitals pay the costs of serving persons who have been rejected by insurers. This was the first time a bill proposed using differential funds for a particular purpose, rather than simply paying them to the hospitals.

Increasing the Differential to 24%

53. During 1991, a debate began regarding whether the differential should be increased above 13% and closer to the level which existed in the 1970's before the Legislature specified a differential in statute. The discussion was fueled by financial difficulties of Empire Blue Cross and Blue Shield caused in part by the loss of several hundred thousand good risk customers from Empire's community rated programs. *See* Affidavit of Jerry Weissman submitted herewith. Attached as Exhibit "N" is a copy of a letter sent by the Blue Cross lobbyists to legislative leaders alerting them to the problem and urging legislative action to solve the problem. Similar letters were sent to a variety of legislative leaders and the Governor's office.

54. The calls for an increase in the differential were in recognition of the fact that the skimming or cherry-picking by certain commercial insurers of the Blue Cross Plans' good risk groups had greatly accelerated in the late 1980's and early 1990's. When an insurer can avoid 30% or more of average health care costs through the use of medical testing and rejecting applicants who have a history of needing medical care, the insurer can obtain a competitive advantage that more than offsets the 13% differential. This "cherry-picking" occurs frequently today due to the use of sophisticated blood tests (such as HIV testing) as well as commercial insurers longstanding refusal to issue coverage to certain industries. In order to restore a level playing field, the Legislature determined that the differential would have to be increased in order to be commensurate with the competitive advantage obtained from selective underwriting practices.

55. For example, over the last six years, Empire has lost more than 500,000 of its good risk small group customers, roughly half of its community pools. In 1986, Empire had a ratio of good risks to poor risks in the small group pool of 10:1. By 1991, the ratio was only 3:1 because of the cherry-picking.

56. When the good risks (those having health care costs lower than average) are cherry-picked out of the Blue Cross community pools by virtue of the commercial insurer risk selection and marketing practices, it has a significant impact on premiums, since the average cost of insuring persons with higher than normal health care costs must necessarily rise to reflect the loss of persons whose costs were less than average. This results in increased premium rates. This creates a spiraling effect where the Blue Cross premiums rise and the remaining good risk groups covered by Blue Cross are again lured away, thus necessitating another rate increase for Blue Cross' remaining subscribers. From the public's perspective, health insurance becomes more and more unaffordable.

1991 Legislative Hearings

57. In 1991, the State Assembly Insurance and Small Business Committees held a joint hearing to consider proposals for health insurance reform. Early in 1991, the Governor had introduced a bill to reform the health insurance process for small groups and individuals so that no insurer could blacklist industries or reject applicants due to their health status. Since such a bill would force commercial insurers to behave in some ways the same as Blue Cross and Blue Shield, the question was raised whether the differential should be increased as well (as Blue Cross suggested) or be eliminated (as the commercial insurers suggested).

58. The testimony of the Superintendent of Insurance before the Assembly Committee is attached as Exhibit "O". On pages 13-14, the Superintendent pointed out the contrasting positions

regarding whether the differential is sufficient compensation to Blue Cross for its less restrictive insurance underwriting practices and community rating method of establishing premium rates. The Superintendent clearly articulated the linkage between the differential and the insurance marketplace. All parties clearly viewed the differential as compensation for the unique Blue Cross underwriting activities. The only dispute was whether 13% was adequate compensation. In a subsequent portion of the hearing, the Superintendent and Assemblyman Lasher, the Chair of the Assembly Insurance Committee, engaged in an extended dialogue regarding the variety of instances where Blue Cross performs different insurance related services, or is regulated by the Insurance Department, in a different fashion than commercial insurers (pages 27-35).

The 1992 Legislative Efforts To Increase the Differential—The 1992 State Budget.

60. In January of 1992, the Governor submitted his proposed budget for the State's fiscal year which was to begin in April of 1992. The budget contained two provisions to reform the health insurance market. First, an increase in the differential to 25%, the level of the differential during the 1970s and early 1980s. Secondly, the Budget sought the enactment of the underwriting and premium-setting reforms the Governor had proposed in 1991.

61. As discussions progressed regarding the proposal to increase the differential, questions arose regarding the use of the funds which would be generated by the differential. Traditionally, the monies from the differential were paid to the hospitals as part of the hospitals' rate, and the hospitals retained the monies as compensation for rendering services. Beginning in 1991, the hospitals had received over $450 million in new revenues as a result of other legislative changes in the hospital rate-setting system. *See* Public Health Law §2807-c(1)(e)(iii). Department of Health officials, therefore, stated that they did not want any

additional differential monies to remain with the hospitals. A program providing free health insurance to young children without health insurance, for which funding was inadequate, was considered as a recipient of the new monies. This proposal was similar to the Gottfried underwriting allowance bill which had proposed using the funds from the underwriting allowance differential to pay for care by persons rejected by insurers. Eventually, it was decided to turn the money over to the State Treasury to help close the State's enormous budget gap.

1992 Legislative Hearings

62. In March 1992, as the Legislature was well into its budget negotiations, the State Senate Insurance Committee held a hearing to discuss the Governor's reform proposals. A copy of the testimony provided by the Superintendent of Insurance is attached as Exhibit "P". The Superintendent explained the insurance underwriting process and what he perceived as the drawbacks to that process. On pages 6 and 7, he pointed out that commercial insurers believed the 13% differential is ample compensation to Blue Cross for its socially desirable underwriting practices, while Blue Cross believed the 13% differential is not sufficient. The Superintendent made a further reference to the differential when he noted that the Governor's bill required HMOs to make their coverage available on an open enrollment basis. He explicitly stated that HMOs have benefited from the differential but have not performed the community service of open enrollment, and the Governor's bill "would correct this inequity." *See* Exhibit "P" at p. 11.

63. In summarizing his testimony, the Superintendent stated:

> "When one carrier assumes the social responsibility of insuring all those that the others reject, it is becoming clearer that the current hospital differential and favorable

tax treatment are insufficient to offset the costs associated with accepting poorer risks."

See Exhibit "P" at p. 14.

April 1, 1992 Opinion and Decision on Rate Increases

64. Coinciding with the legislative events described above was the proposed April 1, 1992 effective date of a rate increase application submitted by Empire Blue Cross and Blue Shield to the Superintendent. The Superintendent granted a two part rate increase, specifically stating that he would rescind the second part if the Legislature enacted sufficient reforms. The Superintendent stated that passage of the Governor's bill "which contains provisions to require community rating and open enrollment, coupled with a change to the hospital reimbursement rates paid by commercial insurers, will provide the framework for Empire's long-term financial recovery by creating a more equitable playing field and correcting prior imbalances." *See* page 12 of the Opinion and Decision from April 1, 1992, attached as Exhibit "Q". In July of 1992, the second part of the rate increase was rescinded by the Superintendent.

The Final Results

65. Following extensive negotiations with the Legislature, the differential was increased by an additional 11% (total differential—24%) for commercial insurers in the April 1992 Budget bill, a copy of which is attached hereto as Exhibit "R". Other parties subject to the 13% differential (no-fault auto insurers, workers' compensation programs, volunteer ambulance and firefighter programs and self-insured plans, etc.) remained at the 13% level and were not subject to the extra 11%. The differential was increased only for the period from April 1, 1992 to March 31, 1993, the State's fiscal year.

66. The proposed reforms of the insurance underwriting and premium-setting process were separated from the budget negotiations. However, three months later the Legislature passed, and the Governor signed, Chapter 501 of the Laws of 1992 which implemented those reforms.

Veto Message of July 24, 1992

67. After the differential was increased to 24% effective April 1, 1992, further legislation was introduced which sought to require commercial insurers to pay the additional 11% directly to the State, rather than for the insurers to pay the hospitals and then have the hospitals remit the funds to the State which is the present method of payment. The Governor vetoed this bill. *See* attached Exhibit "S" for a copy of Veto Message #14. The veto occurred for other reasons, but it is important to note that the Governor commented in the veto message that one of the reasons the differential was increased to 24% was to provide "competitive support for Blue Cross, which serves higher risk residents."

D. CONCLUSION

66. A review of all the materials above compels the conclusion that for over 30 years the differential has been the State's primary tool to encourage insurers to engage in socially desirable practices of issuing health insurance on an open enrollment basis and determining premium rates on a community rating basis. In other words, the differential has been used as an incentives to insurers in an attempt to manipulate insurer practices so that insurance products would be delivered to the insurance buying public in a fashion which facilitates public health and insurance policy. These efforts are the heart of the State's long-term effort to regulate insurer behavior and the business of health insurance in order to attain the State's policy goal of broad availability of health insurance at affordable rates.

67. All other aspects of the differential have been ancillary to the efforts to regulate insurance. The hospitals do receive revenues from the differential paid by commercial insurers and other payors. Part of the justification for the differential is the savings or convenience which Blue Cross provides to hospitals. And beginning in 1992, the revenues from the extra 11% differential were diverted from hospital coffers to the State Treasury. Which party is the beneficiary of the differential payments has never constituted the primary goal or purpose of the differential. From the Trussell Report in 1958 to the Governor's Veto Message in July 1992, the long-standing, recurrent theme of the differential has been to regulate insurers and their marketplace so that the State could attain its public policy goal of opening insurers' doors to those who otherwise would likely not be able to obtain health insurance.

ALBERT F. ANTONINI

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Daniel Sisto, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Daniel Sisto, being duly sworn, deposes and says:

1. I am President of the Intervenor Hospital Association of New York State ("HANYS"). In this position, I am familiar with the operation and circumstances of hospitals throughout New York State and have an intimate knowledge of the State's hospital reimbursement system. I have been involved, in one position or another, in hospital care and its financing for over 15 years and therefore am familiar with the evolution of our hopsital reimbursement system over the past several years.

HANYS is a not-for-profit trade association whose membership includes over 240 general hospitals, all of which are not-for-profit, voluntary or public providers of hospital services in New York State. HANYS provides technical, administrative, legal, and lobbying services on behalf of its members, and regularly interacts with legislative and executive branch officials over existing and proposed legislation. HANYS also follows health care activities, including hospital reimbursement initiatives throughout the country. As a result of my affiliation with HANYS, therefore, I have personal knowledge of the matters related in this affidavit.

2. This affidavit is submitted in support of HANYS' cross-motion for summary judgment and in opposition to the plaintiffs' motions for summary judgment which are pending before this Court.

The position of HANYS in these litigations is to defend the legality of the 13% differential contained in Public Health Law section 2407-c(1)(b). The hospitals take no position on the 11% tax enacted this year as sections 348 and 349 of Chapter 55 of New York's Laws of 1992. The reason for this dichotomy is the significant and historical difference between the 13% differential and the 11% tax. As explained below, the 13% differential has been, in one form or another, a major component of the integrated, all-payor reimbursement system that has developed over a span of 14 years. The 11% tax, on the other hand, is a recently-enacted legislative measure designed to raise revenues for the State.

Under the statutory scheme in sections 348 and 349, the 11% add-on to payments made by commercial insurers is passed through to the State's general fund. A copy of these sections is annexed hereto as Exhibit A. Thus, hospitals derive no benefit, and in fact incur losses, under this statutory scheme. The 11%, therefore, is simply a tax on commercial insurers. At present, under a preliminary injunction in another action, the State is enjoined from requiring hospitals to pay the 11% estimated payments over to the State.

This scheme, as explained below, is in sharp contrast to the 13% differential, which has always been an integral component of the hospital reimbursement system. For this reason, the hospitals, through HANYS, are supporting the legality of the 13% differential, but are taking no position on the 11% differential.

3. In this affidavit, I will therefore describe the background of the 13% reimbursement differential (the "differential"), the re-

imbursement system now extant in New York and the place of the differential in the system, the importance of the differential in the financing and operation of hospitals, and the implications of voiding the differential. As the Court will see, plaintiffs are not really attacking a unique element of a reimbursement system that unfairly impacts on employee benefit plans. Rather what plaintiffs are actually challenging is the right of the Legislature to establish a comprehensive reimbursement system that determines the reimbursement rates for all payors.

HISTORY OF THE DIFFERENTIAL

4. Plaintiffs in this action have neglected to describe why and how the differential was established and instead have portrayed this feature as an additional and unfair fee levied against them. On the contrary, the 13% differential has evolved from circumstances which the commercial insurers and others found intolerable and has its roots in attempts to alleviate commercial insurers' concerns.

5. During the 1970's, payments for hospital services, particularly for patients insured by commercial insurance, were largely unregulated. Commercial insurers were billed for services to the insureds based upon the hospital's charges, which were set on a hospital-by-hospital basis, without a limit. From the mid-70's, commercial insurers and others complained that hospitals' charges had escalated dramatically and disproportionately. As a result, Chapter 517 of the Laws of 1978 was enacted. This statute froze hospital charges at May 1, 1978 levels. As of January 1, 1979, charges could only increase based on an inflation formula which, according to the statute, would be developed by an independent panel of expert economists.

6. When the legislation which became Chapter 517 was awaiting the Governor's signature, the Division of the Budget observed; "This bill will help control the escalating cost of hospital

charges to private patients and patients covered by commercial insurance carriers." In addition, the Budget Division also said; "This bill is an important step toward a uniform system of hospital reimbursement which should keep hospital costs at a reasonable level, eliminate subsidization of one type of payor by another, and reduce the administrative complexities of the current system." The Budget Division's memorandum is attached as Exhibit "B."

7. At the same time, the State Insurance Department observed (see Exhibit C annexed hereto):

> This legislation also "freezes" the hospital's regular charges established for in-patient services for all persons utilizing such services at the level of charges in affect May 1, 1978 (except in the case of a successful appeal). This will prevent hospitals from increasing charges at an uncontrolled rate and also protect those payors not currently included in the cost containment mechanism from being unfairly and inequitably charged for hospital services because no controls exist as to such payors."

8. There was recognition at that time that the charge control and other features of Chapter 517 were not sufficient to establish a uniform and comprehensive reimbursement system. The Governor, on approving Chapter 517, stated that "[t]hree of the bills . . . provide a reasonable approach to the containment of hospital costs during the period of time needed to develop the uniform system of hospital reimbursement which I have advocated." (Governor's Approval Memorandum on Chapters 517, 518, 519 and 520 of 1978, dated July 25, 1978; Exhibit "D.")

9. Enacted along with the charge control law was Chapter 520 of the Laws of 1978, which established the Council on Health Care Financing. The Council was charged with the responsibility of proposing a new system for financing general hospital inpa-

tient care. It was required to issue a report by the end of 1979 and from that report, it was anticipated, would emanate legislation to establish a uniform reimbursement system.

10. The Council on Health Care Financing, pursuant to Chapter 520 of the Laws of 1978, consisted of a broad array of representatives of state government, the hospital industry, and various payors, including the commercial insurers. The Council issued its first report in October 1980 and addressed, among other things, the issue of charges for commercial insurers, as well as the difference in rates paid between commercial insurers and others, such as Blue Cross. Certain insurers, such as Blue Cross plans, did not pay hospitals based upon their charges, but rather based upon the hospitals' costs, which were significantly lower. Even with the freezing of charges in 1978, the Council recognized that the difference between cost-based payments and hospital charges did not provide for an equitable reimbursement scheme. This problem had persisted because charges had been frozen at levels which were widely disparate. Each hospital had been free to establish its own charge levels, so that charge levels varied hospital by hospital, with no uniformity.

11. Based on data available at the time, the Council report indicated that hopsital charges ranged from a low of 113% of cost-based payments, to a high of 136%, with the average at approximately 125%. With the objective of establishing a reasonable payment differential, the Council recommended a flat uniform differential rate which was below the lowest charge level of any hospital at the time. Relevant portions of the Council's 1980 report are attached as Exhibit "E."

12. Nearly two years elapsed from the Council's 1980 report and the enactment of Chapter 536 of the Laws of 1982, the first comprehensive uniform reimbursement legislation. Chapter 536 enacted Public Health Law §2807-a (renumbered in 1987 as Public Health Law §2808-c) to govern payments to hospitals by

all payors: Medicaid, Blue Cross plans, commercial insurance, self-pay patients, health maintenance organizations, workers' compensation, no-fault, and even the federal Medicare payment system. The text of Chapter 536 reflected certain changes which had been negotiated from the time of the Council report until the enactment of the law.

Subdivision 13 of then §2807-a provided that, during 1983, charges would continue to be frozen and subject to adjustment only for inflationary purposes as dictated by the independent panel of economists. Subdivision 6 of that section provided that for the years 1984 and 1985, charges would be limited to three categories: if a hospital's average charges were no more than 12% higher than the cost-based rate, then charges could not, for that period, exceed 12% of the cost rate; if charges were between 12% and 15% above the cost rate, they could remain at those levels, and within that corridor; if charges exceeded 15% of the cost-based rate (which the Council had observed two years earlier would have been the case with most hospitals), then charges would have to be reduced so as not to exceed 15%.

Thus, the "differential" was first statutorily established as a direct state cost control measure on hospitals, limiting their ability to charge commercial and other charge payors widely varying and excessive amounts. It became an integral piece of the first state comprehensive "all-payor" reimbursement system. The differential, therefore, was not an add-on to hospital rates to be paid by commercial insurers; it was a limitation on the amount commercial insurers could be charged.

13. The purpose of the differential was expressed by the Division of the Budget, which stated (see Exhibit F annexed hereto):

> Due to the fiscal constraints . . . self-pay patients and commercial insurers were required to shoulder much of the burden of financing costs not reimbursed by other

payors. Even with existing charge control limitations, self-pay patients and commercial carriers argued that an unreasonable proportion of costs were incorporated in their charges for services. With enactment of this legislation, uncompensated liabilities will be more equitably distributed to all payor sources (i.e., through the Bad Debt and Charity Care Fund) and self-pay and commercial charges will be more reflective of the actual cost of providing services.

14. In view of the purpose of this legislation, it is not surprising that it was supported by the commercial insurance industry. Significantly, the Health Insurance Association of America, one of the plaintiffs in these actions, wrote to then Governor Carey expressing its "strong support" for the legislation and urged the Governor's approval. The letter from HIAA (annexed as Exhibit "G" stated in part:

> For more than a decade, the health insurance industry has expressed growing concern not only over the drastic rise in health care costs nationwide, but also with the fragmented, arbitrary and unfair health care reimbursement practices in New York State. We have advocated establishment of a uniform prospective reimbursement system based on a definition of hospital full financial requirements that would meet hospital financial needs and was fair to all third party payors.

15. Thus, the differential served two purposes. First, it more severly limited the amount charge payors, including commercial insurers, would have to pay for hospital services. Second, it was a key element in the development of a uniform, comprehensive prospective reimbursement methodology which encompassed all payors of hospital care. The Plaintiff HIAA endorsed both concepts.

16. The inpatient reimbursement system enacted in 1982 was, and still is, commonly referred to as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). The provisions enacted in 1982, known as "NYPHRM I," were by their own terms to last for three years, 1983 through 1985.

17. In 1985, the Legislature enacted NYPHRM II by Chapter 807 of the Laws of 1985. Chapter 807 renumbered the old Public Health Law §2807-a as P.H.L. §2808-c, and inserted a new §2807-a. This statute completed the transition from a fragmented charge system to a uniform charge system. In subdivision 12 of the new §2807-a, charges were not to be more than 12% higher than the Blue Cross rate. Variations were no longer permitted and uniformity had been reached.

18. When the legislation which was to become NYPHRM II was awaiting gubernatorial action, Plaintiff HIAA again wrote to the Governor to urge approval. (See Exhibit "H"). HIAA did address the differential, recommending that differentials be based on objective standards. Notably, HIAA did not question the validity of a differential, but simply expressed the desirability of further inquiry into lowering it. Similar views were also expressed to the Governor's office by the Metropolitan Life Insurance Company. (Exhibit "I"). Again, therefore, the uniform 12% differential established in 1985 addressed in part the concerns of the commercial insurance industry for a uniform and lower differential. Those amendments to NYPHRM continued to be supported by the commercial insurance industry generally, and HIAA specifically.

19. NYPHRM II governed inpatient reimbursement for the years 1986 and 1987. As had occurred in the past, a bill was passed by the Legislature in 1987 which would have governed reimbursement as of January 1, 1988. The NYPHRM III bill contained a uniform 13% differential. HIAA again wrote to the Governor, expressing its support for the NYPHRM III bill and

urging the Governor not to veto it. (HIAA's letter of July 10, 1987 is attached as Exhibit "J"). HIAA also sought the implementation of a "case payment" system for all payors, including commercial insurers.

20. There was considerable opposition to a number of features of the proposed NYPHRM III. A major issue that developed was what reimbursement system would be in place if the NYPHRM III bill were vetoed. It was recognized that with the expiration of NYPHRM II on December 31, 1987, and no new system created in its place, the State control over rates paid by commercial insurers would dissolve. This was of major concern to commercial insurers, including HIAA, which wrote that, "a veto of this proposal would result in a legislative framework devoid of effective charge control and open to the unabated cost shifting which occurred prior to NYPHRM." (Exhibit J). The prospect of a return to pre-NYPHRM times was anathema to the commercial insurers.

21. Attached to the HIAA letter of July 10, 1987 was a series of suggested improvements for a NYPHRM III system. On the question of a differential, HIAA suggested that a series of differentials be enacted. HIAA did not assert that any differential would be preempted by ERISA or otherwise illegal. HIAA merely requested that the issue of the size of the differential be further studied by the Council on Health Care Financing's Subcommittee on Insurance.

22. Governor Cuomo vetoed the July 1987 legislation for reasons unrelated to the differential. It was only in January 1988 (Chapter 2 of the Laws of 1988) that the NYPHRM III law was enacted, containing an across-the-board 13% differential. The law also provided for exactly what HIAA had requested, a charge to the Subcommittee on Insurance to study and report on the differential issue. (L. of 1988, Ch. 2, §21).

23. The Subcommittee, in which HIAA participated, issued its report on March 31, 1989. The report reviewed all previous studies and examined insurance industry practices. The report recommended retention of the differential, with its application linked to insurers' practices. (The Subcommittee report is attached as Exhibit "K").

24. In 1990, the current system, NYPHRM IV, was enacted as Chapter 907, to govern reimbursement from 1991 through 1993. Consistent with the Subcommittee report, which HIAA had sought and in which it had participated, NYPHRM IV maintains the 13% differential. (P.H.L. §2807 c[1][b]). This is the differential Plaintiffs now challenge. It is the same differential that, in slightly differing amounts and form, existed since 1982 and was supported by the commercial insurance industry, particularly Plaintiff HIAA.

THE HOSPITAL REIMBURSEMENT SYSTEM

25. With the enactment of NYPHRM III in 1988, a case payment system was established for most patients, based on diagnostic related groups (DRGs). This is a payment technique implemented by the federal government for the Medicare system in the early 1980's. It was replicated in the NYPHRM system as a cost control measure and had been advocated for by HIAA (Exhibit "J"). Current P.H.L. §2807-c, which governs the in-patient hospital reimbursement methodology for all payors, is a lengthy and complex statute. One component of this statute, found in section 2807-c(1)(b), provides that commercial insurers and self-insured funds which provide reimbursement on an expense incurred basis (as well as Workers' Compensation, No-Fault and a host of other payors) pay a rate based on the applicable DRG, but which includes the 13% differential.

26. As noted above, the differential payment is an integral piece in the overall reimbursement system which has existed in

New York State for a decade. It is only one of many adjustments made to a DRG rate to arrive at a particular payor's reimbursement rate for hospital servies to its insureds. Plaintiffs now single out this individual component of the methodology as objectionable, challenging on ERISA preemption grounds a feature of the system that they supported since 1982.

27. Plaintiffs' tactics are problematic for at least two reasons. First, because the reimbursement methodology is integrated, the disruption of certain portions such as the differential necessarily would affect the entire system. Second, plaintiffs' approach is riddled with inconsistency in that there are numerous other features of the system which also apply to self-insured and commercially insured plans, but which have gone unmentioned.

28. The reimbursement methodology found in section 2807-c of the Public Health Law is intended to accomplish several objectives. First, it is intended to provide hospitals with the financial resources that are reasonable and adequate to meet the costs of an efficiently and effectively operated facility. Second, it is intended to distribute those costs equitably among all payors. Third, it is intended to meet the needs of all patients for hospital services, regardless of their source of payment, if any. Fourth, it is intended to provide a measure of stability and predictability, so that hospitals can budget and plan for the development of new services, the acquisition of new equipment or the renovation or new construction needs of the hospital. Fifth, it is intended to maintain open access to hospital services.

The integrated all-payor reimbursement system reflects the realities of the system of providing hospital care. Hospitals exist to serve entire communities, not isolated subgroups in the communities. Over the course of time, all types of patients will need hospital care, and they will need different levels of resources. In order to meet these demands, a hospital must be fully staffed and equipped at all times. The reimbursement system responds to this

community need by providing for payment levels which allow for the staffing to be maintained even though, for example, on a particular Tuesday a particular patient may not need all the resources which are otherwise available. The reimbursement system incorporates the various needs of different patient classes and then establishes, in general, appropriate rates which must be paid in order for those patients to be served. If, however, a certain payor class refuses to participate in the system as it is constructed, the hospital as an operating entity is threatened. When a hospital is threatened, all patients, including those patients whose payors are refusing to participate in the system, are deprived of the access to and quality of care which they now receive.

29. The "integration" of the hospital financing system is accomplished in a variety of ways. The basic feature of our current system is the use of DRGs. The DRG system pays a hospital an amount depending on the patient's condition, regardless of how long the patient is hospitalized. The general concept behind DRGs is that a patient with a particular condition requires a particular level of resources to be treated appropriately. While the "basic" DRG is designed to be sensitive to individual patient resource consumption, the rate-setting process, and by extension the entire reimbursement system, necessarily accounts for other phenomena which are not all traced to individual cases. The method for accounting for these phenomena is a series of adjustments which are applied to arrive at *all payors'* rates.

30. The current payment system uses 1981 as a "base year" for determining the costs of care. The 1981 base costs are "trended," *i.e.*, generally adjusted for inflation, to the rate year, the year in which a rate is to be paid. The initial trending of base year costs, on its own, however, results in a skewed profile of costs since not all costs have moved in a uniform pattern consistent with general inflationary trends.

31. For each rate year, a "trend factor," *i.e.*, the inflation adjustment, is set using projected estimates. Subsequently, the projected trend is further adjusted using actual economic data. For example, the "trend" portion of 1992 rates consists of projected 1992 inflation, and adjustments for 1990 and 1991 estimated trends now adjusted to actual. The recalculation of prior years' trend factors and the setting of the upcoming year's estimated trend is an annual event.

After trending, there are scores of adjustments and calculations made, for all payors, to arrive at a particular year's rate. The calculations to derive a rate are complex and lengthy. Each hospital at the beginning of a rate year, is issued a "rate sheet" describing the calculations for that hospital. Currently, a typical hospital "rate sheet" is an inch-thick document of tables, calculations and adjustments. Among the adjustments are the following:

a) Adjustments due to a hospital's successful prosecution of an appeal of its rate level for a prior year. (P.H.L. §2807-c[9][b]). Since each year's rate in part depends on a prior year's rate, altering the latter necessarily alters the former. It may take two years from the close of a rate year before an appeal is finally decided, so that the disposition of just one appeal has a multi-year, cumulative impact. On average, about 1,800 appeals are filed each year by all hospitals;

b) A volume adjustment which adjusts the costs upon which a rate is based, depending on whether the total volume of patients entering the hospital increased or decreased beyond a certain threshold in the prior year (P.H.L. §2807-c[9][f]);

c) Special adjustments for teaching hospitals, which are hospitals which have medical residence programs. Beginning in 1992, these adjustments were further refined depending on the type program, *i.e.*, primary care or specialty, and the number of students. (P.H.L. §2807-c[25]);

d) Adjustment for "rural" hospitals, depending on location. (P.H.L. §2807-c[4][f]);

e) An adjustment to eliminate the hospital's cost for treating Medicare patients, since Medicare is a federal program and the state system governs only reimbursement for all non-Medicare patients (P.H.L. §2807-c[11][g]);

f) A calculation of the amount of charity care and bad debts experienced by hospitals and mechanism for partial and redistributive payments for such charity care and bad depts. (P.H.L. §2807 [14, 14-a, and 14-c]);

g) A "case mix" adjustment to account for an increase in the overall severity of hospitalized patients' conditions from year to year. (P.H.L. §2807-c[11][f]). The case mix adjustment is subject to a limit which will be described more fully below;

h) Various adjustments for "inlier" and "outlier" cases, which refer to patients whose stays at the hospital are extraordinarily long, short, or costly. (P.H.L. §2807-c[4][b]-[d]);

i) An "ALC" adjustment. (P.H.L. §2807-c[4][h]). Patients who remain hospitalized usually awaiting nursing home placement and who are receiving nursing-home level care at the hospital are referred to as alternate level of care, or "ALC" patients. This adjustment carves out a hospital's ALC costs, because these costs are reimbursed under a different methodology;

j) A variety of adjustments for so-called "enhancements" to rates, discussed further below, to reflect the unusually rapid cost increases in nursing and other professions' salaries, malpractice insurance, waste removal,' infection control supplies (gloves, gowns, etc.) and other items. (P.H.L. §2807-c[1][e]);

k) Adjustments for a hospital's capital expenses. (P.H.L §2807-c[8]); and

l) An adjustment to generate funds supporting primary care initiatives in underserved areas. (P.H.L. §2807-c[14-b]).

32. The purpose of listing some of the numerous adjustments made to each hospital's base rate is to illustrate the steps leading to the rate which is used. After the above and other adjustments are made for each hospital, further calculations are made. Each hospital is grouped with a number of peer facilities which share certain characteristics. The hospitals' costs, calculated as described above, are averaged to arrive at a "group average" price. (P.H.L. §2807-c[7]). The rate which is finally issued for a hospital is a blend; 55% is the group average and 45% is the hospital's specific cost. (P.H.L. §2807-c[5][b][iii]).

33. These various adjustments and all payors' rate are interdependent and take into account the differential and the payors whose rates include the differential (commercial insurers, self-insured plans, Worker's Compensation, No-Fault and others). The process ultimately relies on all patients' needs for hospital care and participation by all payors.

34. I should emphasize that the rate promulgation process is applicable to all non-Medicare payors. For example, there is no exemption from one calculation for certain payors. This is so because the rate making process is an attempt to allocate both patient-specific and more generalized costs among all users and payors of hospital care.

35. The current reimbursement system, as stated above, is a complex statute with a variety of features. Plaintiffs have chosen and easily identifiable portion to attack, while ignoring many others. For example, in addition to the various adjustments and calculations described above, the current NYPHRM system con-

tains many "enhancements." Subdivision[1][e] of §2807-c provides for hundreds of millions of dollars to be added to reimbursement rates, in the aggregate, to reflect increased nursing salaries and other labor costs, the cost of malpractice insurance, waste disposal costs and other items whose costs have increased far above normal inflationary factors. These enhancements have been built into the system, i.e., into all payors' payment rates, to recognize that without these funds to support these services and demands, hospitals would be unable to provide care. Yet, Plaintiffs are silent as to these items. These enhancements and the previously-described adjustments affect or relate to ERISA plans no differently than the 13% differential, or even the DRG system itself. Many other examples exist.

36. Subdivision 3 of P.H.L §2807-c is a detailed statutory framework for establishing the diagnosis related groups and the "weights" which are assigned to these groups in order to ascertain appropriate reimbursement rates. These provisions are fundamental to a DRG payment system, and yet Plaintiffs fail to comment on the propriety of the methodology which directly determines what rates a plan or any other payor pays.

37. In addition, Plaintiffs notably do not challenge the provision in subdivision 11(e) which provides that if a bill is paid within 10 day of its receipt, the payor may reduce its payment by 2%. Apparently, Plaintiffs are satisfied to retain this portion of the statute, making no claim that the item which saves the Plaintiffs some money is preempted by ERISA.

38. Similarly, in paragraph (f) of subdivision 11, there are extensive provisions that limit so-called case mix increases. These are payment increases which result from two phenomena; the increase in intensity of patient needs (increases in the number of sicker patients who use more resources), and so-called case mix "creep," which is an increase in billings due to billing coding practices. The statute caps the amount by which rates may

rise due to case mix increases and virtually eliminates any possibility of case mix creep, thus regulating what would otherwise be payment increases. The Plaintiffs have no complaint with this provision of the statute and yet it certainly affects ERISA plans as much as the differential.

IMPORTANCE OF THE DIFFERENTIAL TO HOSPITALS

39. As described above, the differential has been a constant statutory feature of the reimbursement system for a decade. It is a component of rates paid, not only by commercial insurers and self-insured plans, but also by a host of other payors for hospital services rendered. The differential is income to hospitals to offset the costs of providing services to patients. As operating income for ten years, the differential plays a fundamental role in hospitals' planning, budgeting and delivering of service. Across the hospital system, it is not a paltry sum: currently the 13% differential from all payors provides about $160 million in operating income annually to hospitals statewide.

40. This income is not newly created. The differential has been a steady and necessary source of financial support for hospital services. Indeed, the abrupt termination of this support would cause havoc with hospitals' ability to continue services at their present levels. Budgeting for ongoing operations or new initiatives would immediately be jeopardized, with a resultant diminution of access to and quality of the hospital care now being provided.

41. The differential has been incorporated into all hospitals' revenue estimates because it is an integral feature of the rates paid for services rendered. The revenue, in fact, has been used to pay nurses salaries, make capital improvements, purchase needed equipment, open clinics and support the myriad of activities which constitute the operation of a hospital. The historic stability and predictability of this revenue has caused it to be routinely

budgeted and utilized for several years. As a result, hospitals anticipate the continued availability of this operating income.

The financial picture of hospitals throughout this state is bleak. Most hospitals have been experiencing operating losses for several years, and of the few that have been operating profitably, the positive margin is razor thin. Further losses may lead to serious reductions in services.

42. The removal of the revenues from the differential will undoubtedly affect services. Hospitals services are provided not for the hospitals' benefit, but for all patients' benefit, including patients with commercial or self-insured plan coverage. Thus, the ultimate impact of a revenue loss of this magnitude will be felt by all patients.

IMPLICATIONS OF VOIDING THE DIFFERENTIAL

A. *Lack of Uniformity*

43. The plaintiffs' attempts to characterize elimination of the differential as a means to achieve payment uniformity are fallacious and misleading. Nationally, there is only one "uniform" hospital reimbursement scheme, i.e., the federal Medicare program which insures the elderly and certain disabled individuals. As to rates paid by commercial insurers and self-insured plans, no uniform model exists. Rather, each state, like New York, has established its own payment system, and each state's system and rates are different.

For example, a variety of states have all-payors systems, while others do not. Some states provide for cost-based reimbursement, while other states have charge-based or a DRG-based system. In many states, rates are simply negotiated between the hospitals and certain payors, without statutory controls. Thus, not only are

the rate methodologies entirely different is each state, but different hospitals have different rates within each state.

44. Eliminating the differential will not make New York's system "uniform" with the other states. It would simply make New York different is a different way. Each state has its own unique system; with or without the differential, there will continue to be 50 different payment systems and New York's would continue as a unique system. Elimination of the differential has nothing to do with nationwide uniformity. Within New York State, should the plaintiffs prevail, the present level of uniformity would actually be destroyed.

45. The essence of the present dispute is whether the State may mandate the components of a rate to be paid by employee benefit plans, together with all other payors. Should the Plaintiffs prevail, the State's authority to set plans' rates would be invalidated. The result would be an unregulated "system" in which each hospital would set its own rate for employee benefit plans. Where there is now uniform rate regulation, there would instead be *ad hoc* rate charging by the some 270 hospitals in the State. To characterize this outcome as "uniform" is patently ridiculous. This is exactly the chaos lobbied against by HIAA when it fought the veto of NYPHRM III. (See paragraph 19 above and Exhibit J annex hereto). While Plaintiffs have exhorted the catchphrase "uniformity" for its ERISA arguments, they have not referred to a single aspect by which reimbursement systems or rates are uniform anywhere in the country.

B. *Destruction of the Comprehensive System*

46. I have described that loss of the $160 million in operating revenue attributable to the 13% differential would be devastating to hospitals and patients. (paras. 39-42). The further effects of striking down the differential also merit description.

47. The differential is inextricably linked to the setting of plans' rates, and the setting of *all* payors' rates in an interrelated process. Not only would voiding of the differential lead to uncontrolled rates paid by ERISA plans, but it would substantially influence all other payors' rates to an extent which can be described, but candidly is not quantifiable.

48. As I described above (para. 25-38), the State's hospital reimbursement system is "integrated" *i.e.*, all payors' rates are set by allocating among all payors the costs of operating all hospitals. The system of allocation is in recognition of the fact that the patients covered by all payors rely on hospitals for their care. The balance among payors responsibilities for support of the hospital system is only maintained if all payors participate. Instability in one sector necessarily influences the others since each component, *i.e.*, each payor, is integral to the operation of the hospital system as a whole. We may assume that maintaining a viable hospital system is a reasonable goal which is not to be abandoned. If so, then for the "whole" to remain while one component has effectively withdrawn leaves the remaining payors (and their rates) to maintain the balance.

49. The reallocation of the hundreds of intricate adjustments, weights, limits, additions, exceptions and cost accounting procedures in the wake of uncontrolled commercial payments would be nothing short of chaotic. The chaos of which I speak is not bureaucratic chaos. It is the real-world day-to-day ability of each hospital to project its income and maintain costs within that level. The task would require a fundamental restructuring of each hospital's financial profile with a concomitant re-examination of patient care expenses and costs allocations.

50. The disruption in the ability of hospitals to maintain their viability and services would be widespread. The hospital financing system has evolved from an *ad hoc* unintegrated model to a comprehensive all payor structure, in an attempt to accommodate

all patients' changing health care needs. Patients' needs would be ill-served if we returned to the result advocated by the plaintiffs.

51. I understand that one of HANYS' affirmative defenses is the doctrine of laches, which involves unreasonable delay and prejudice. The delay in challenging the 13% differential is unreasonable, since a differential has existed in the law since 1982. Further, it was instituted for the benefit of commercial insurers, to limit the charges they would have to pay, and to establish uniformity. Plaintiff HIAA itself repeatedly lobbied in favor of these differentials.

The damage to the integrated all-payor system generally, and hospitals particularly, from the invalidation of the 13% differential would be tremendous and extremely prejudicial. Since the 13% differential relates to ERISA plans no differently than any of the myriad of other adjustments, enhancements and components of the reimbursements system, Plaintiffs are really challenging the right of a state to establish a hospital reimbursement system that applies to all payors, including employee benefit plans. The undue delay and prejudice from such a late challenge is indisputable, since this uniformity has been the structure around which all reimbursement legislation has been built since NYPHRM I.

For the foregoing reasons, I respectfully urge that the Plaintiffs' request for summary judgment be denied and that HANYS' cross-motion for summary judgment be granted.

DANIEL SISTO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Kathryn Allen, filed October 20, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Kathryn Allen, being duly sworn, deposes and says:

1. I am the Executive Director of the New York State Health Maintenance Organization Conference and make this affidavit in support of the motion for summary judgment submitted by plaintiff Health Insurance Association of America, *et al.* and in opposition to defendant's cross motion for summary judgment.

2. The New York State Health Maintenance Organizations Conference is a not-for-profit corporation consisting of 27 health maintenance organizations ("HMOs") licensed to operate in and located throughout New York State. The HMOs in the Conference currently provide health care to more than 2.5 million people in New York. The twelve individual HMOs who also have intervened serve approximately one million people in all parts of the State.

3. As Executive Director of the Conference, I am fully familiar with the operations of HMOs throughout the State. Prior to becoming Executive Director of the Conference, I was the director of marketing for Health Insurance Plan of Greater New York, the largest HMO in the State and one of the oldest in the country. I

also served as the vice-president, marketing at Rutgers Community Health Plan in New Jersey.

A. HMOs AND THEIR ROLE IN NEW YORK'S HEALTH CARE SYSTEM

4. HMO coverage differs from traditional health insurance. By combining hospitalization coverage with the provision of care, HMOs have the incentive to provide high quality health care in the most cost efficient way possible. HMOs accomplish this through a variety of contractual arrangements with doctors, other providers and hospitals. For example, some HMOs (group and staff models) employ their own physicians who act as the primary caregiver to the HMO subscriber. Other HMOs (individual practice associations or "IPAs") use networks of physicians who agree to serve the HMO's subscribers and adhere to the HMO's practice and payment guidelines.

5. HMOs use a number of tools to control the cost of health care, including emphasizing primary and preventive care, managing the delivery of care and seeking to eliminate unnecessary or excessive hospital stays. In recent years, the increase in the cost of HMO premiums has been significantly less than the increase in other types of health insurance.

6. HMOs generally do not themselves provide in-patient hospital care. Rather, HMOs operate as third-party payors of in-patient hospitalization. The cost of hospital reimbursement is a substantial expense of the HMOs and therefore directly affects the cost of health care to HMO members.

7. Unlike commercial insurers which have traditionally relied on experience rating, and unlike Blue Cross organizations, which experience rate groups with more than fifty members, HMOs community rate everyone: large groups, small groups and individuals. HMOs also are required to provide open enrollment to all

groups of five or more employees and last year served approximately 250,000 small group members.

8. HMOs are required by state and federal law and regulations to offer a comprehensive benefits packages. While each HMO's benefits package may have distinctive features, they all share an emphasis on primary and preventive care and cover a wide range of illnesses and conditions. HMOs may not revise their benefits packages at will and may not reduce their package beyond a certain level of benefits.

9. Many HMOs are non-profit, including seven of the individual HMOs who have also intervened in this action. Other HMOs are small and still struggling to increase their membership. Most HMOs do not have large financial reserves that can absorb major and unexpected costs. While HMOs retain reserves, these are to be used for unexpected claims and are not available for unexpected operational costs. In the face of such costs, HMOs are forced to seek rate increases.

10. Finally, unlike other insurers, HMOs serve Medicaid recipients. Under the State's Medicaid managed care program, HMOs enroll Medicaid recipients into their managed care networks and receive a fixed monthly rate for each individual. The HMO bears the full risk for the cost of providing care to the Medicaid member. This is in contrast to the usual Medicaid fee-for-service arrangement in which the Medicaid provider receives a fee for each visit or service. HMOs also insure that Medicaid recipients and their families have a primary physician who monitors their care on a regular basis. This and the availability of a health care network helps reduce costly emergency room visits.

B. HMOs AND EMPLOYEE BENEFITS PLANS

11. In developing their health care benefits packages, many employee health benefit plans seek to provide a choice between

indemnity insurance and HMOs. In addition, State and federal law requires employers (and employee benefits plans) to offer their employees the choice of at least one HMO. Most HMO contracts are with employee benefit plans.

12. After an employee benefits plan contracts with an HMO, the employees and their families must select a primary physician. This is usually a pediatrician for children and an internist for adults. Many women select an obstetrician/gynecologist as their primary physician.

13. The physician has primary responsibility for overseeing the care that is provided. By designating a primary physician, the HMO insures that there is one individual who understands the medical history and needs of each employee and their families. In most cases, members must receive the approval of the primary physician before being referred to a specialist.

14. HMOs also work closely with the patients prior to and during a hospitalization to insure that there is adequate preparatory work and to minimize the length of the hospital stay.

15. As noted above, in some cases the HMO's physicians are salaried employees of the HMO and are available only to serve the members of the HMO. Thus, if an employee benefits group leaves the HMO, the employees and their families cannot continue to use the physicians who they have been using and who may be most familiar with their medical history.

C. HMOs AND NEW YORK'S HOSPITAL REIMBURSEMENT SYSTEM

16. HMOs receive the benefit of the 13% differential. This is because HMOs are required to community rate all of their members, open enroll all groups of five or more and provide extensive community service. The differential also reflects the fact that

HMOs enroll subscribers without imposing preexisting conditions and provide comprehensive benefits packages.

17. HMOs are allowed by statute to negotiate alternative rates with hospitals. HMOs authority to negotiate rates reflects a recognition that HMOs' managed care systems are able to reduce significantly the cost of hospitalization. These rates are set by contract and are outside the case-based payment system. For example, HMOs subscribers often have shorter lengths of stay than people with similar illnesses who are enrolled in Blue Cross or other insurance companies. In fact, many HMOs experienced significant increases in the overall cost of hospitalization when the state moved from a per diem system of reimbursement to a case based system. This was because HMOs were able to minimize the length of stay relative to other insurers and thus had relatively lower costs under a per diem system.

D. THE STATE'S IMPOSITION OF THE 9% SURCHARGE

18. In April, the State enacted a new 9% surcharge on HMO inpatient care. The 9% is not an increase in the rates that HMOs pay hospitals. Rather, it is a separate charge that is based on the aggregate monthly cost of the in-patient hospitalization paid by an HMO. It is paid directly to a statewide pool and thereafter deposited into the State's General Fund. In the case of HMOs who have negotiated alternative hospital rates, the 9% is assessed over and above the negotiated rate.

19. Under the statute, HMOs can reduce or eliminate the 9%. For the 1992 rate year, an HMO could eliminate the 9% surcharge if it (1) had Medicaid contracts with every county in which it operated and (2) had enrolled within less than one month of the enactment of the statute a defined target number of Medicaid recipients.

20. For any HMO that did not already have contracts in place and a substantial enrollment, meeting the standards was virtually impossible. The process for obtaining a county contract generally takes at least nine months and HMOs have experienced substantial delays in obtaining contracts from some counties. Some counties have refused to negotiate contracts with HMOs. Since enrollment in an HMO is not mandatory, it can take many more months for an HMO to achieve the enrollment targets.

21. While a few HMOs were able to eliminate or reduce the 9% surcharge for the 1992 year, there is no assurance that they will continue to be able to do so because the enrollment target increases every year. In addition, because there is no across-the-board mandate on Medicaid recipients to enroll in an HMO, some HMOs with sufficient enrollment in one year may lack the requisite enrollment in the next year and thereby become subject to the 9% surcharge.

22. The surcharge has had an immediate and dramatic effect on the rates that HMOs must charge their subscribers. Since the cost of hospitalization accounts for approximately 30% of the overall costs of an HMO, the 9% surcharge translated into an immediate 2.5-3.5% increase in costs for most HMOs.

23. HMOs cannot absorb this increase. They cannot use reserves, which must be retained in the event that an HMO experiences unusually heavy medical claims. Nor can they use corporate profits since most HMOs are non-profit. Thus, they are forced to pass the surcharge on in the form of higher rates.

24. Because the surcharge occurred in the middle of the rate year, most HMOs could not seek an immediate rate increase without going through a special procedure, and they were explicitly discouraged from doing so by the Insurance Department. However, those HMOs that have sought rate increases have received them.

25. In its decisions to award increases, the Insurance Department specifically cited the 9% surcharge as the basis for at least part of the increase.

26. For many HMOs, the outlook for next year is not encouraging. Although many HMOs now have contracts pending with counties or awaiting approval by the State, it is unclear when the contracts will be finalized, and some HMOs must obtain contracts with as many as twenty counties. Moreover, even if an HMO is able to obtain the requisite contracts with a sufficient number of counties, there will be little time to enroll the number of Medicaid recipients necessary to hit the targets. Thus, those HMOs will continue to pay the 9% at least through 1993. Finally, as noted, the target number increases in subsequent years so even those HMOs who now do not pay the surcharge may be forced to begin paying it in future years.

27. By April of 1993, many HMO subscribers will be paying an additional 2.5-3.5% in their rates.

28. Accordingly, the plaintiff's motion for summary judgment should be granted to the extent that it seeks to strike down the 9% surcharge and the defendant's cross-motion for summary judgment should be denied.

KATHRYN ALLEN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Paul V. Bruno, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

PAUL V. BRUNO, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for in-patient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore R. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Sales Director, Managed Care and Employee Benefits, Albany, New York. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers and the types of services which The Travelers provides to both insured and self-insured group health plans. In my position I work primarily with group health plans of 500 lives or more.

3. I understand that, in opposition to the motions of the plaintiffs for summary judgment, the interveners, The New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue

Cross and Blue Shield repeatedly claim that Blue Cross/Blue Shield plans are losing business at an accelerating and alarming rate because commercial insurance companies have been "cherry-picking" their best customers.

4. From my experience, "cherry-picking" is not an issue with respect to the market I primarily deal with (group health plans of 500 lives or more). In this size market, from the competitive situations I have seen over the years, Blue Cross/Blue Shield offers experience-rated programs and self-insured claims administration. "Cherry-picking" is simply not an issue in the medium-customer and large-customer market.

5. With respect to group health plans of 500 lives or more, my experience is that ERISA plans change from Blue Cross/Blue Shield to The Travelers for reasons that have nothing to do with cherry-picking or community rating, but rather simply that the customer believes The Travelers performance is superior to that of Blue Cross/Blue Shield in areas such as (a) information technology, providing the customer with access to Travelers advanced systems enabling them to respond to employees' benefit inquiries, review claim data, handle eligibility questions, monitor banking arrangements, and other items; (b) fast, accurate claims service, including responsiveness to inquiries from the customer's employees; (c) medical management features which encourage covered individuals to seek quality, yet cost effective, medical care; and (d) plan flexibility, tailored benefit packages to suit the needs of a particular customer, based on the make-up of its employees, including wellness programs, a maternity intervention program, and various claims management programs. Finally most ERISA group health plans of 500 lives or more, that changed from Blue Cross/Blue Shield to The Travelers, complained that they were unhappy with the service provided by Blue Cross/Blue Shield.

WHEREFORE, it is respectfully submitted that The Travelers motion for summary judgement should be granted.

PAUL V. BRUNO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Terence D. Tuohy, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

TERENCE D. TUOHY, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for in-patient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore R. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Vice President, Managed Care and Employee Benefits, East Hartford, Connecticut. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers, and the types of services which The Travelers provides to insured group health plans. In my position I work primarily with group health plans of 2 to 50 lives at present, although my area of responsibility will be evolving to include group health plans of 2 to 200 lives.

3. I understand that, in opposition to the motions of the plaintiffs for summary judgment, the intervenors, The New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield repeatedly claim that Blue Cross/Blue Shield plans are losing business at an accelerating and alarming rate because commercial insurance companies have been "cherry-picking" the best customers from those plans.

4. Premium rates are very important in a highly competitive market to be sure. However, from my experience, ERISA plans change from Blue Cross/Blue Shield to The Travelers for many other reasons which have nothing to do with community rating by Blue Cross/Blue Shield or risk underwriting rules utilized by The Travelers. Rather, customers come to The Travelers for a wide variety of reasons, including:

a. the fact that The Travelers name is an old and respected name in the health insurance field;

b. the broad array of products, available through The Travelers, including unmanaged indemnity, managed indemnity, preferred provider organizations, point of service plans in some areas, health maintenance organization plans in some areas, and variations on these options;

c. high levels of efficient and responsive customer service, including the fact that The Travelers is highly automated and, for example, customers can receive employee booklets within 48 hours of entry of the relevant data into the system;

d. the offering of ancillary benefits, including life insurance, dental insurance, and insurance for lost wages while out on disability;

e. the fact that The Travelers has four claims offices dedicated exclusively to handling claims for the 2 to 50 life market;

f. the fact that The Travelers is a strong supporter of the agency system, as we believe smaller, less sophisticated employers benefit significantly from the assistance of an agent in the complex world of health coverages today;

g. enhanced claim review and claims payment processes which result in high quality care, yet appropriate, cost effective care.

WHEREFORE, it is respectfully submitted that The Travelers motion for summary judgment should be granted.

TERENCE D. TUOHY

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Richard W. Landen, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

RICHARD W. LANDEN, being duly sworn, deposes and says:

1. I am an independent health care consultant. Between September 1987 and September 1992, I was a full-time employee of the Health Insurance Association of America ("HIAA") in Washington, D.C. From 1987 through 1990, I was the Associate Director of the HIAA's Insurance, Managed Care and Professional Relations Department. One of my primary duties was representing the HIAA in matters relating to hospital reimbursement issues in New York State. Prior to joining the HIAA, I was Assistant Administrator at the New York Infirmary Beekman Downtown Hospital (NYIBDH), a not-for-profit voluntary acute care hospital in New York City. I was at NYIBDH for eight years, beginning in 1978 as an administrative resident. I hold the degrees of Master of Public Health and Master of Business Administration, conferred by Columbia University in New York City, where my academic concentration was health care administration. I am familiar with the operation of the hospital reimbursement system in New York State.

2. I submit this affidavit in support of the plaintiffs' motions for summary judgment in *The Health Insurance Association of*

America, et al., v. Chassin, et al. and *The Travelers Co. v. Cuomo, et al.*, and in opposition to the cross-motions filed in both actions.

3. I have reviewed the affidavits submitted by the State defendants and the Intervenors in these actions. The purposes of this affidavit are: (a) to respond to the State defendants' and Intervenors' characterizations of the 13% differential and its predecessors; and (b) to demonstrate that the commercial insurance industry, through the HIAA (a trade association of hundreds of private insurance companies) has objected to the differentials throughout their history.

A. SUMMARY.

4. At the outset, I note that the history of the differential is not as the State defendants and Intervenors would have it. They seek to portray the differential as a device designed by the Legislature to level the playing field between Blue Cross and the commercial insurance industry. The facts, however, are somewhat different. As described below, the differential sprung from an unregulated market. Hospitals were limited in the amounts by which they could raise Blue Cross rates, but were not similarly limited with respect to private sector charge payors. This situation led to a gross disparity in the rates at which Blue Cross plans and other payors (such as commercial insurers and self-insured plans) reimbursed hospitals for inpatient care. When New York enacted its first cost-control legislation, the differential was arbitrarily frozen into the law. Further, committees that have been charged with the responsibility of studying the differential have conceded that it lacks a quantifiable basis and should be phased out.

5. Further, throughout the NYPHRM era, the commercial insurance industry has objected to the differential, specifically noting that it lacks any quantifiable basis and has outlived the historical conditions that created it.

B. THE "MARKETPLACE" IN WHICH THE DIFFERENTIAL OPERATES.

6. In seeking health care benefits, employee benefit plans and others seeking health coverage have two principal objectives. First, they seek to protect themselves against the risk of catastrophic health care costs that would jeopardize their financial position. Second, they seek to minimize the costs of that coverage—by, among other things, paying premiums no larger than those justified by their risk, controlling the amount of claims paid, and capturing savings they are able to achieve.

7. These objectives have different implications for different types of plans. For instance, relatively large group plans often conclude that their best option is to bear most or all of their own risk. Because of their size, those plans may be in a position to cover the risk of catastrophic losses that materialize for only a relatively few participants, and they often have the incentive and the ability to control their own costs (perhaps with the help of a commercial insurer) and to capture resulting savings.

8. By contrast, smaller groups and individuals often seek coverage primarily as protection against the risk of losses they themselves would be hard-pressed to bear; they may choose to share their risk by purchasing insurance and contributing premiums to a pool used to pay claims. Intermediate options, involving some combination of risk sharing and risk retention, may be selected, depending on the characteristics of a given group and its willingness to assume risk.

9. Various forms of health coverage are available to satisfy the varying needs of employee benefit plans and others. Some are insurance and some are not. Specifically, plans may choose to self-insure (with or without stop-loss coverage that limits their retained risk), to participate in HMO's, or to purchase insurance.

Insurance is available on terms that involve more or less sharing of risk.

10. Commercial insurers and Blue Cross compete in providing coverage through a number of these mechanisms. In addition to providing coverage on a community-rated basis, Blue Cross administers self-insured employee benefit plans, offers insurance on an experience-rated basis (tying premiums to claims experience), and operates HMO's. Indeed, more than two-thirds of the Intervenor Empire Blue Cross and Blue Shield's premiums are derived from insurance that is not community-rated.

C. HISTORY OF THE 13% DIFFERENTIAL.

11. The affidavit of Albert F. Antonini begins its discussion of the "Historical Use of [the] Differential to Regulate Insurance Markets" by referring to the Trussell Report (*see* Antonini Aff. ¶¶ 15-20 & Exhibit A.) The New York Legislature commissioned the Report in the late 1950's as part of a sweeping study of the New York State Blue Cross Plans. However, this Report says nothing about the differential. Indeed, it suggested that Blue Cross income be supplemented by public subsidy (*see id.* p. 44)—not by charges levied on Blue Cross's competitors in the health-care coverage market.

12. Prior to New York's adoption of the prospective hospital reimbursement methodology (known as "NYPHRM") in the early 1980's, the State did not regulate the ways hospitals charged or the rates at which commercial insurers and self-insured plans reimbursed hospitals for inpatient care. These entities reimbursed hospitals according to the hospitals' charges. In 1969, a prospective payment system was set up; this system limited hospital reimbursement rates for Medicaid and Blue Cross. During the 1970's, an inflation "trend factor" was established which set permissible yearly rate increases for Blue Cross. No such limitation was set for commercial insurers or self-insured plans. This

rate of increase destroyed any incentive for Blue Cross to develop hospital cost-control programs with the result that hospitals looked to charge-payors to capture cost elements not realized under the Blue Cross prospective payment system. Further, where yearly Blue Cross rate increases were insufficient to meet the financial needs of individual hospitals, they were free, until 1978, to escalate their charges. This led to a significant cost shift to charge payors. Thus, the Blue Cross discount grew larger.

13. In 1978, a charge control system was put in place for hospitals, covering all patients. This system limited the yearly rate of increase in charges to an overall hospital inflation rate. This system, however, froze the existing differential, and maintained the burden placed on charge-paying patients.

14. NYPHRM-I codified the differential for the first time, and set the maximum differential at 15%. Significantly, the method chosen to do this was for the State Health Department to require hospitals to set aggregate charge levels at no more than 15% above their Blue Cross reimbursement rate. Thus, the concept was targeted at all payors, including uninsured individuals, not just insurance companies.

15. The Hospital Association of New York State ("HANYS") is incorrect in stating that the HIAA "strong[ly] support[ed]" the NYPHRM-I legislation. Even a cursory reading of the basis for that assertion—a July 12, 1982 letter from HIAA to Governor Carey (*see Sisto* Affidavit ¶ 14 & Exhibit G)—demonstrates HIAA's concern with the "fragmented, arbitrary and unfair health care reimbursement practices in New York State." Significantly, this letter states in part that the NYPHRM-I legislation "continues to permit payment inequities among third-party payors that are not yet objectively justified." Thus, the HIAA's support of NYPHRM-I certainly was not without reservation. Its support of the legislation was driven by its recognition that NYPHRM-I was "a major step towards" a system uniformly fair to all "third party

payors." From the outset, however, the HIAA made its objection to the differential clear.

16. While the first NYPHRM legislation was in effect, the New York State Hospital Review and Planning Council ("SHRPC") undertook a study of the differential, pursuant to a legislative mandate in the NYPHRM law. The "Charge Differential Analysis Committee" (otherwise known as the "Komaroff Committee," after its chairperson, Mr. Stanley Komaroff) of the SHRPC conducted the review. The Komaroff Committee solicited interested parties to submit papers on the value of the Blue Cross discount, including recommendations regarding maintenance or modification of the Blue Cross discount on and after January 1, 1986.

17. The HIAA submitted a paper, dated December 28, 1984, which directly challenged the justification of the differential. In that paper, a copy of which is annexed hereto as Exhibit A, the HIAA noted the following:

- No quantification of the value of the Blue Cross discount was made before it was incorporated into New York's hospital revenue control law; instead, it was related to the historical discount enjoyed by Blue Cross. The historical discount arose from New York's imposition of a prospective payment system only on Medicaid and Blue Cross. This system restricted rates of increase of Blue Cross payments to hospitals. It was in recognition of a lack of basis for the differential that the Legislature mandated that the SHRPC determine its true value.

- MNYPHRM-I was enacted in 1982 to impose a more rational system of cost control on hospitals. The statute broke new ground in incorporating charge and other payors with Medicare, Medicaid and Blue

Cross into a uniform hospital reimbursement system.

- Experience in Maryland and New Jersey, where Blue Cross enjoyed large discounts and large market shares prior to regulatory action significantly lowering the discount in those states, demonstrated that Blue Cross market share remained virtually unchanged.

- The NYPHRM-I discount (a maximum of 15%), although less than some historical, pre-NYPHRM differentials that operated in Blue Cross's favor, nevertheless was not cost-justified. It was a purely arbitrary figure temporarily imposed pending completion of a study of the value of Blue Cross practices.

- Blue Cross was still being rewarded for practices that met needs existing in the 1930's and 1940's. Those needs, however, had since been addressed by the introduction of Medicare and Medicaid. By virtue of these programs, the elderly and the indigent received coverage for health care services through state and federal tax dollars.

- Further, access to private health insurance for employed segments of the population was met equally well by commercial insurance and Blue Cross policies. The then-current marketplace dominance of the Blue Cross plans was due to the fact that they enjoyed a differential allowing them to offer a product similar to that being offered by commercial carriers at a much lower price. This advantage was magnified by tax exemptions which the commercials were not allowed.

18. Significantly, the HIAA stated that there was no data to justify the existing differential:

> The NYPHRM legislation calls for Blue Cross to have no more than a 15% discount until December 31, 1985, with a discount to be set by the SHRPC, not to exceed 12%, to be effective after that date. There was no study or data submitted by any parties during the NYPHRM legislative discussions surrounding this issue that attempted to quantify what, if any, value there is to Blue Cross practices that merit a discount of any magnitude. The decision regarding an interim discount was not based on a quantitative evaluation of Blue Cross activities aimed at reducing hospital costs. Because of the complexity of the issue, it was agreed by all interested parties that an objective evaluation should be deferred until after NYPHRM was implemented. The commercial insurance industry agreed not to oppose the interim Blue Cross discount with the understanding that the SHRPC would undertake a determination of its true value.

19. In May 1985, the Komaroff Committee submitted its first report to the SHRPC regarding the differential (the "first Komaroff Report"; *see* Antonini Aff. Exhibit E). The first Komaroff Report explicitly noted that "the basis of the differential is not currently susceptible of precise quantification, and historically has not been so." (*Id.* at pp. 3-4.) It also noted that the "social policy factors" purportedly justifying the differential "and the cost or price thereof are in large part subjective, conjectural and uncertain." (*Id.* at p. 5.)

20. The first Komaroff Committee, believing in "gradualism," recommended that in the years 1986 and 1987, the differential be reduced to 12%, contingent upon expansion of the open enrollment periods of all the Blue Cross plans. The Committee recommended that in 1988 the differential be further reduced to 10% unless prior to that time the SHRPC decided otherwise. It also called upon the SHRPC to begin further review of the appropriateness of the differential in 1987. (*Id.* at pp. 8-9, 11.)

21. The dissent to the first Komaroff Report, registered by one of the Committee members, Bernard Handel, went even further. A copy of Mr. Handel's dissenting report is annexed hereto as Exhibit B.

22. Among other things, Mr. Handel noted that "the overwhelming majority" of comments and reports received by the Committee (which were not summarized in its report) favored a reduction in the differential and negotiation between individual employee benefit plans and hospitals regarding the details of reimbursement. (Exhibit B, hereto, at p. 1.) Some of Mr. Handel's additional points included the following:

- The differential is not quantitatively defensible. (The Committee actually agreed with this point.)

- Gradual reduction in the differential should be expedited and started in 1986.

- An excess differential provided to any one carrier lessens competition among insurance companies and self-insured plans and leads to higher premiums.

- The evidence submitted to the Committee indicated that the then-existing differential "far exceeded its desired social objective of subsidizing losses incurred by Blue Cross in meeting identifiable social objectives."

- New York State policy should not single one carrier out for protection; it should be equitably applied to all third-party payors.

23. NYPHRM-II, enacted in 1985, set the differential at 12%. Once again, as the HANYS notes, HIAA wrote to the Governor's Counsel and recommended that the legislation be approved. (*See*

Sisto Aff. ¶ 18 & Exhibit H.) It noted that NYPHRM was "preferable to the method of hospital reimbursement which previously prevailed," but at the same time urged that New York "promptly begin to develop the details of a comprehensive, long term solution to hospital financing in New York." In addition, HIAA made the following recommendations, among others:

- New York's hospital reimbursement system should be revised to permit all payors to negotiate reimbursement agreements with hospitals, provided they do not operate to shift costs among payors.

- The differential should be given further study, and continuing attention should be paid to its reduction.

24. NYPHRM-III was passed in January 1988 and governed reimbursement for inpatient hospital care until December 31, 1990. This legislation contained a 13% differential. Once again, HIAA supported the legislation, rejection of which "would result in a legislative framework devoid of effective charge control and open to the unabated cost shifting which occurred prior to NYPHRM." (Sisto Aff. Exhibit J.) At the same time, and as it had done in the past, the HIAA outlined its "concerns" with the bill. (*Id.*) Among other things, the HIAA opposed the "undefined, unquantified granting of a differential to Blue Cross, HMO's and Medicaid which amounts to a 13% mark-up of rates" to other-payors; instead, the HIAA recommended that payment rates be set equitably for all payors "based on the resource consumption of the payor or group of payors participating in the system." (*Id.*)

25. It is worthy of note that NYPHRM-III provided for a reduction of 2% in the differential applicable to a commercial insurer that practiced open enrollment practices and charged rates comparable to Blue Cross during a period set in the statute. Similarly, the law provided for a 2% reduction in the differential

applicable in any region where the Blue Cross plan with the largest number of subscribers was not practicing open enrollment practices during the periods set forth in the statute. (*See* Antonini Aff. Exhibit G.) Thus, the New York Legislature effectively conceded that the economic worth of the differential's social value was 2% rather than 13%.

26. Pursuant to legislative direction in NYPHRM-III, the Komaroff Committee undertook another review of the differential.

27. Once again, the HIAA submitted its views in a paper, dated November 4, 1988, a copy of which is annexed hereto as Exhibit C. In this paper, the HIAA made its opposition to the differential clear, noting that whatever the past merits of awarding the differential might have been, there was no longer any basis for doing so. The HIAA pointed out the following, among other things:

- Despite Blue Cross's philosophy of pursuing social policy objectives, New York had the highest rate of uninsured in the Northeast, to the tune of some 2.4 million.

- The GAO concluded that there was little difference between Blue Cross plans and commercial insurance; Blue Cross's federal tax exemption thus was removed.

- The differential imposes an adverse impact on commercial insurers and other charge payors.

- Blue Cross was then selling an increasing percentage of experience-rated contracts, which at that point amounted to nearly 80% of all hospital certificates issued by Empire Blue Cross.

- Blue Cross was expanding its ASO business, in which it acts as third-party administrator for self-insured groups.

28. In February 1989, the Komaroff Committee issued its second report, roughly four years after issuing its first. (A copy of the second Komaroff Report is annexed as Exhibit K to the Antonini Affidavit.) Despite the passage of time, however, the second report stated that "[n]o calculation can be formulated to precisely quantify the appropriate differential level." (Antonini Aff. Exhibit K at p. 4.)

29. With regard to the social policy factor, however, the second report recognized, among other things, that

- There had been a reduction in the number of subscribers recruited through open enrollment policies.
- Blue Cross had shifted a significant number of subscribers from community-rated to experience-rated plans.
- There was "ample (and distressing)" evidence of a rise in the number of the uninsured and under-insured in New York, notwithstanding the existence of the differential.
- Blue Cross had taken advantage of the differential in situations where it functioned merely as the third-party administrator of plans underwritten by other insurers (*i.e.*, Blue Cross functioned as the administrator pursuant to an ASO Agreement).

Despite the absence of "precise information regarding the value of the differential," the second report recommended that the differential of NYPHRM-III be continued in 1991 (and for a

"reasonable period" thereafter). At the same time, however, the second report stated that there was no "unanimity" regarding this position, and that the differential "should be reduced on a gradual basis, and ultimately phased out, except to the extent that a direct and quantifiable link can be forged between the differential and appropriate social goals." (Antonini Aff. Exhibit K at p. 7.)

30. In March 1989, the Subcommittee on Health Insurance of the New York State Council on Health Care Financing also issued a report regarding the differential. (A copy of this report is annexed as Exhibit L to the Antonini Affidavit.) The Subcommittee Report noted that "it is difficult to precisely set and value the appropriate differential level." (Antonini Aff. Exhibit L at p. 5.) As had the Komaroff Committee, the Subcommittee Report recommended that the differential be continued in 1991 and for a reasonable period thereafter, but it acknowledged that it did so "in the absence of precise knowledge of the nature of the post-NYPHRM III hospital inpatient reimbursement system, and other public policy objectives which might be undertaken to achieve the objectives which the differential is intended to achieve." (*Id.* at p. 6.)

31. Thus, the groups that have been charged with the responsibility of studying the differential have conceded that it lacks a quantifiable basis, and should be phased out.

32. The differential was carried over into the next phase of NYPHRM legislation. In 1990, the New York Legislature enacted NYPHRM-IV. NYPHRM-IV contains a 13% differential and regulates the rates at which hospitals are reimbursed for inpatient care for the period January 1, 1991 through December 31, 1993. I am informed by counsel that the 13% differential of NYPHRM-IV is challenged in this lawsuit on ERISA preemption grounds.

33. In sum, the history recounted above shows that the New York Legislature and the committees assigned the task of study-

ing the differential were responsive to the HIAA's position that the differential lacked an objective justification. Thus, there was cause for optimism that, in light of the absence of such a justification, the differential would be reduced or eliminated.

34. Finally, I note that to the extent the differential has been subjectively justified as a reward for Blue Cross's community-rating and open-enrollment practices, in July 1992, Governor Cuomo signed legislation (Chapter 501 of the Laws of 1992) requiring commercial insurers to adopt these practices, effective April 1, 1993, in their underwriting of individual and small group plans. Thus, Blue Cross can no longer claim an entitlement to the differential based on its assertedly "unique" implementation of these practices.

WHEREFORE, it is respectfully submitted that plaintiffs' motions for summary judgment should be granted.

RICHARD W. LANDEN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Chris Petersen, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

CHRIS PETERSEN, being duly sworn, deposes and says:

1. I am employed as Senior Counsel to the Health Insurance Association of America ("HIAA"). In that capacity, I have concentrated in state legal affairs and for the past three years, I have had direct responsibility for New York legislative actions impacting the health insurance industry. I understand that plaintiffs in these actions are challenging, on ERISA preemption grounds, the 11% surcharge recently enacted in Section 348 of New York's Omnibus Revenue Act of 1992 (the "Omnibus Act"). I further understand that plaintiffs in the action entitled *The Health Insurance Association of America, et al. v. Chassin, et al.*, No. 92 Civ. 5419 (LJF), are raising a similar challenge with regard to the 9% surcharge recently enacted in Section 349 of the Omnibus Act. I frequently traveled to New York to engage in lobbying activities with regard to these surcharges, and was extensively involved in formulating industry positions with respect to them. I an familiar with the surcharges' legislative history.

2. I submit this affidavit in support of the plaintiffs' motions for summary judgment in *The Health Insurance Association of America, et al. v. Chassin, et al.* and *The Travelers Insurance Co.*

v. Cuomo, et al. and in opposition to the cross-motions filed in both actions.

3. I understand that the State defendants, Intervenor Blue Cross and Blue Shield and Intervenor New York State Conference of Blue Cross and Blue Shield Plans characterize the new 9% and 11% factors as nothing more than extensions of the 13% differential, thus portraying them as the same thing — a State imposed discount favoring Blue Cross as a reward for its pursuit of socially desirable goals. This is a mischaracterization. The 9% and 11% factors are designed to assist in balancing New York's budget.

4. Indeed, Governor Cuomo's Memorandum in support of a proposed predecessor to Section 348 of the Omnibus Act (which would have imposed an additional *12%* on the amounts commercial insurers paid to hospitals for the cost of inpatient care instead of the 11% ultimately contained in the Omnibus Act) succinctly stated as follows:

> Enactment of this bill is necessary to implement the Governor's plan to eliminate the deficit for the 1991-92 Fiscal Year.

A copy of the this Memorandum is annexed hereto as Exhibit A.

5. The Bill Memorandum accompanying Assembly Bill A.10565 (the Omnibus Act) similarly provides:

> This bill contains the revenue and financing measures necessary to complete the 1992-1993 State budget.

A copy of this Memorandum is annexed hereto as Exhibit B.

6. In remarks recorded prior to the New York Senate's vote on S.7589 (the Bill that became the Omnibus Act), various Senators

noted that these new factors unfairly discriminate against commercial insurers and will lead to increases in insurance premiums, all in the name of balancing New York's budget.

7. For example, Senator Solomon stated, in part, as follows:

> The message is clear that we'll balance this budget by raising the cost of health insurance and raising hospital costs instead of taking actions that could reduce fees for doctors and hospitals and attempts to limit those costs.
>
> * * *
>
> We have now placed an additional 11 percent surcharge against private health insurance carriers in this State. Do we take the money and use it for the health care system? Nope. We take it and we put it in our general fund.
>
> * * *
>
> * * * [W]e've even tacked 9 percent onto the HMOs in this state because we want to make sure that a lot of the people share in this increase in health insurance costs and health care costs.

(*See* Exhibit C, hereto.)

8. Thus, it is clear that a purpose of the 9% and the 11% surcharges was to balance New York's budget. Although Blue Cross endorsed the legislation as a means of enhancing its position in the marketplace, this was not the sole or even the main purpose of the legislation.

9. Finally, I understand that the Intervenors argue that plaintiffs' challenges to the 13% differential are barred by the doctrine of laches since, according to Intervenors, the HIAA supported the

differential throughout its history and allegedly unreasonably delayed its challenge until it brought this lawsuit. As recounted in the affidavit of Richard W. Landen, submitted in further support of plaintiffs' motions, the HIAA actually has opposed the differential throughout the NYPHRM era. The differential generally has followed a downward trend since the pre-NYPHRM years. As a result, the commercial insurance industry was optimistic, based on reviews of the differential conducted by direction of New York's Legislature, and the HIAA's participation therein, that it could use New York's legislative and regulatory processes to eliminate the differential. However, enactment of the new 11% surcharge sent the commercial insurance industry a clear message that it could no longer rely on these processes to achieve its goal.

WHEREFORE, it is respectfully submitted that plaintiffs' motions for summary judgment should be granted.

CHRIS PETERSEN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Jerry Weissman, filed October 29, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JERRY WEISSMAN, being duly sworn, deposes and says:

1. I am Chief Financial Officer of Empire Blue Cross and Blue Shield (hereinafter "Empire"), a member of the New York State Conference of Blue Cross and Blue Shield Plans (hereinafter "the Plans"), both Intervenors in this action. I execute this Affidavit in Reply to the Affidavits of Paul V. Bruno and Terence D. Tuohy submitted in further support of Plaintiff Traveler's motion for summary judgment and the Affidavits of Richard W. Landen and Chris Petersen submitted in further support of Plaintiffs HIAA'S, *et al.* motion for summary judgment.

2. In the aforementioned affidavits, the Plaintiffs attempt to: (1) minimize the significant differences between the Blue Cross and Blue Shield Plans and commercial insurers *(see* Bruno and Landen Affidavits); (2) establish that the lower premiums offered by commercial insurers have not caused subscribers to terminate coverage offered by the Plans *(see* Bruno and Tuohy Affidavits); and (3) revise history to distort the purpose of the differential including asserting that the recent additional 9% and 11% differentials were intended solely to redress the State's fiscal problems (*see* Landen and Petersen Affidavits). Plaintiffs' attempts fail because they are not supported by established facts, are inconsis-

tent with legislative history and are, in any event, irrelevant to the legal issue presented.

A. COVERAGE PROVIDED BY PLANS DIFFERS FROM COMMERCIAL COVERAGE.

3. The Bruno Affidavit states that a majority of Empire's business involves large experience rated groups and that Empire gains a large proportion of its premium income from providing this coverage. The implication is that the Plans are no different than commercial insurers and should not have a differential. Similarly the Landen Affidavit attempts to minimalize the importance of the differential to the Plans' ability to operate in their historical fashion by portraying the Plans as operating more and more like commercial insurers.

4. As outlined in my prior Affidavit, ¶¶ 18-23, the purposes and operations of the Plans have been and continue to be significantly different from those of the commercial insurers. These differences are not merely limited to the Plans' community rating and open enrollment, but include operating as not-for-profit corporations, providing advance payments to hospitals and continually being at the forefront of public policy initiatives.

5. Empire's offer of experience rated coverage, similar to the coverage provided by commercial insurers, should not in any way blur the distinction that it operates in a significantly different manner than commercial insurers. First of all, Empire's community rated contracts constitute approximately 30% of its business, which represents health insurance coverage to over 1.5 million subscribers, many of whom could not obtain insurance coverage at all from any of the Plaintiffs. As stated in paragraph 28 of my previous Affidavit, other Plans in the State have a much greater percentage of community rated contracts, and even community rate large groups such as Kodak and Xerox.

6. One way that Empire, as well as the other Plans, can continue to offer individual coverage and Medicare supplementary coverage at premium levels that are affordable, is to subsidize the losses on such coverage to a certain extent. In fact, Insurance Department regulations, 11 NYCRR § 52.40(g)(1), require that the rates on experience rated contracts contain a specific community service factor to be paid into the Plans' reserves to subsidize losses incurred by the Plans on community rated contracts.

7. Any substantial erosion in the Plans' ability to compete in the large group health insurance marketplace would have a direct adverse impact on the Plans' ability to subsidize its community rated contracts and thereby the ability to offer coverage at such affordable prices.

8. Because all of the Blue Cross and Blue Shield lines of business benefit from the differential, the differential permits the Plans to remain competitive so that they can maintain an experience rated base to support their community rated coverage program.

B. COMMERCIAL INSURERS "CHERRY PICK" GOOD RISKS FROM THE COMMUNITY RATED POOLS.

9. In my prior Affidavit, I outlined in detail the deterioration of Empire's small group community rated pools. This deterioration lead to the Legislature's increase in the differential for commercial insurers. Those facts set forth related to small groups only. Therefore, statements in the Bruno Affidavit that cherry picking does not occur in the large group market are irrelevant.

10. The position taken in the Tuohy Affidavit implying that cherry picking does not occur in the small group market is wholly unsupportable. The commercial insurers, including Travelers, have cherry picked from Empire's community rated pools. The

commercial insurers have lured good risks from the pools by offering lower premiums to those groups.

11. Recently, Empire contracted with the Gallup Organization, Inc. (hereinafter "Gallup") to conduct a survey to determine the reasons for its loss of small group customers. Gallup surveyed more than 1,000 group administrators of community rated groups that canceled Empire's coverage during the first eight months of 1991 to determine whether or not those small groups had subsequently purchased coverage and, if so, to obtain information such as the reasons for cancellation and the name of the current health carrier.

12. Of those groups, over 61% terminated their contracts with Empire and obtained subsequent coverage through commercial insurers.

13. The survey further showed that 78% of the groups which purchased coverage from commercial insurers did so because of price: 80% of this amount realized cost savings of over 10% and 43% received savings of 25% or more.

14. The Gallup survey also identified the commercial insurers from which the small groups obtained their subsequent health insurance. Approximately 3% of Empire's lost contracts obtained subsequent health insurance coverage with the Plaintiff Travelers, 4% obtained coverage with Plaintiff Aetna and 4% obtained coverage with Plaintiff Mutual of Omaha.

15. Empire has also determined that groups which were lured away from the community pools to commercial coverage were groups which are healthier than those groups remaining. For example, during 1990, the average loss ratio of groups that canceled in favor of commercial coverage is almost half the loss ratio of Empire's remaining community groups.

16. In fact, the Travelers itself blatantly discriminates in regard to the groups it will insure. Attached hereto as Exhibit "A" is a list of industries to which Travelers will not offer health insurance. So, for example, when Travelers markets groups belonging to Empire's community rated pools, it offers or provides coverage to groups only from particular industries leaving the groups with higher risks in the listed restricted industries in Empire's community rated pool.

17. Due to the cherry picking, there is a higher percentage of poor risks than ever before in Empire's community rated pools. Even a few years ago, there were 10 good risks in the pool for every one poor risk. Now, there are only three good risks for every one poor risk and it appears that the cherry picking is accelerating as the effective date approaches for the mandatory small group community rating and open enrollment requirements.

18. As of April 1, 1993, the effective date of small group community rating legislation, the need and purpose of the differential will not disappear. In any event, the 13% differential will still be in effect, while the 11% differential expires March 31, 1993. As for a differential generally, the Plans will still subsidize individual and Medicare supplemental coverage while Plaintiffs do not. Secondly, it will take several years for the new community rating legislation to have an impact on the Plans' current populations of community rated subscribers. Due to the years of cherry picking by Plaintiffs and other commercial insurers, they have a much smaller proportion of high risk persons in their pools. Conversely, the Plans' community rated pools have a much larger proportion of high risk individuals.

19. In fact, the payment by the commercial insurers of the additional 11% differential would have assisted the Plans in improving their community rated pools before the effective date of the new legislation by putting the Plans in a position to attract some better risks. Unfortunately, since the commercial insurers

have paid no attention to the legislation requiring them to pay the additional 11% in hospital reimbursement, it has had no impact on the Plans' ability to compete for the good risks in the small group market. If an injunction is granted, as requested by Plaintiff Aetna and Mutual of Omaha to relieve the commercial insurers of the requirement to pay the additional differentials, the downward slide of the community rated pools will continue, making it more and more difficult for the Plans to attract new good risks.

C. LEGISLATIVE HISTORY AND PURPOSE OF DIFFERENTIALS.

20. As noted in my prior Affidavit, ¶ 56, HIAA's senior counsel, Chris Petersen, now an affiant in this action on behalf of HIAA, has acknowledged that the purpose of the differential is to compensate the Plans for engaging in community rating and open enrollment. Plaintiffs' Reply Affidavits have made no effort to contradict that statement.

21. Instead, in the Landen Affidavit, HIAA attempts to alter the history and purpose of the differential by raising questions as to whether the value of the differential is quantifiable. However, the appropriate level of the differential is wholly irrelevant to the issue of ERISA preemption.

22. Plaintiffs' dissatisfaction with the Legislature's enactment of the differentials, as set forth in the Plaintiffs' Affidavits, are the same policy arguments which Plaintiffs submitted to the Legislature and the Kamoroff Committee over the years. Having lost those arguments in the Legislature, the Plaintiffs now seek to reargue the merits of their policy views in court.

23. Whether the differential should be 2%, 10% or 50% does not alter the legislative history or purpose of the differential. In enacting the 13% differential, as well as the subsequent differen-

tials, the New York State Legislature has established a value for the community services engaged in by the Plans. Simply stated, the differential has been used by the state in its efforts to level the playing field in the health insurance market place. *See* Antonini Affidavit for in-depth discussion of legislative history. In fact, even Bernard Handel, noted by Plaintiff to be a "dissenter" from the Kamaroff Committee findings, concludes his report (Exhibit "B", p. 4 to the Landen Affidavit) noting that the differential should be reduced, rather than eliminated.

D. DUAL PURPOSE OF DIFFERENTIALS.

24. All of the differentials have been enacted in the State's proper exercise of its police power to regulate cost control and the insurance marketplace. In fact, all of the differentials have a dual purpose. The 13% differential also provides additional revenues to hospitals to provide and improve patient care. *See* Exhibit "E" to Antonini Affidavit, the first Kamaroff Committee Report.

25. The other differentials, the 9% and the 11%, provide additional revenues to the State of New York, rather than to the hospitals.

26. However, the additional differentials were not enacted for the single purpose of providing revenues to the State of New York, as the Affidavit of Chris Petersen asserts. Although the additional differentials were enacted as part of the budget process, the legislative discussions and consideration which lead to the enactment establishes the other purposes sought to be accomplished. As discussed in Paragraphs 49-63 of the Antonini Affidavit, serious efforts to increase the differential from 13% were under consideration since the 1991 legislative session. To attempt to say the additional differentials were enacted solely for revenue raising ignores the testimony at legislative hearings aimed at encouraging insurers to engage in less restrictive underwriting and community rating, *see* Exhibits "O" and "P" to the Antonini

Affidavit. As the Superintendent of Insurance noted in 1992 Senate hearings, "the current [13%] differential and favorable tax treatment are insufficient to offset the costs associated with accepting poorer risks." Exhibit "P" to Antonini Affidavit, p. 14. Furthermore, the Governor reiterated the dual purposes for the increased differentials: to "both raise revenues for the State and provide competitive support for Blue Cross, which serves higher risk residents." Exhibit "S" to Antonini Affidavit.

JERRY WEISSMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Robert A. Sujecki, filed November 6, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

ROBERT A. SUJECKI, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for inpatient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore F. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Assistant Actuary, Managed Care and Employee Benefits. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers, and the types of services which The Travelers provides to both insured and self-insured group health plans. I understand that with regard to the pending motions for summary judgment, the defendants and intervenors have taken the position that plaintiffs have failed to show that the differentials at issue impact the premiums charged to ERISA plans or the benefits provided by such plans. I do not understand how the defendants and intervenors can take this position in light of the affidavit,

sworn to on August 17, 1992, which James M. Gutterman of The Travelers previously submitted in connection with the pending motions for summary judgment. In paragraph 9 of that affidavit, Mr. Gutterman explained that as the costs of the medical treatment covered by The Travelers under a group policy increase, The Travelers passes the costs through to the plan by increasing the premium. In paragraph 14 of the affidavit, Mr. Gutterman explained that with regard to the B.H. Policy, The Travelers sets the premium for the B.H. Policy once a year to reflect the cost of providing coverage, including the cost of inpatient hospital care. He then went on to explain that the 24% surcharge would undoubtedly increase the amount of the premium charged for group accident and health insurance for the beneficiaries of the B.H. Aircraft plan. In light of these clear and concise factual statements, I do not understand how the defendants and the intervenors can take the position that The Travelers might absorb the full impact of the surcharges by reducing its profit margin.

3. Since the 11% surcharge was enacted in April of this year, The Travelers has been increasing the premiums on group accident and health insurance policies when a plan's policy comes up for renewal to reflect the impact of this surcharge. For instance, Denooyer Chevrolet, an insured plan in New York State, recently renewed its group health and accident insurance policy with The Travelers. At renewal, we increased the annual premium for medical benefits on the policy by 7.3%, reflecting projected claim experience and expense charge anticipated for the coming plan year. Of this 7.3% increase, approximately 2.5% was to reflect the 11% surcharge. Other plans have experienced increases in premiums of 2% to 5% as a result of the 11% surcharge. Obviously, if Denooyer Chevrolet did not have to pay this additional premium, it could use the money at issue to provide other benefits to members of the plan or to reduce the overall costs of the plan.

4. The 13% surcharge has existed for a number of years, and I, therefore, cannot point to a specific increase in premiums this year as a result of the surcharge. However, based on a breakdown of the various charges incurred by The Travelers in providing coverage to insured plans, the 13% surcharge represents approximately 2% to 5% of the premiums paid by an ERISA plan for group accident and health insurance. In the case of Denooyer Chevrolet, the 13% surcharge constitutes approximately 3.2% of the health claims.

5. With regard to self-insured plans such as the Sheridan Catheter Plan, the plan pays the entire expense of the 13% surcharge. In the case of the Sheridan Catheter Plan, the 13% surcharge will cost the plan approximately 2.4% of health benefit costs for 1992. Obviously, the plan would use these funds to provide other benefits or to reduce the overall costs of the plan if the 13% surcharge did not exist.

6. In sum, the surcharges at issue here have a material financial impact on both fully insured and self-insured plans. Overall, The Travelers estimates that for the period April 1, 1992 through April 1, 1993, the 13% surcharge will cost the 91 self-insured ERISA plans covering New York residents, with regard to which The Travelers provides claims administration services, a total of $14,000,000. The Travelers further estimates that the 11% and 13% surcharges will cost the 4,338 ERISA plans which receive group health insurance from The Travelers covering New York residents, a total of $24,000,000 for the period April 1, 1992 through April 1, 1993. Obviously, the surcharges have a significant impact on ERISA plans operating in the State of New York.

WHEREFORE, it is respectfully submitted that The Travelers motion for summary judgment should be granted.

ROBERT A. SUJECKI

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Jerry Weissman, filed February 8, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JERRY WEISSMAN, being duly sworn deposes and says:

1. I am the Chief Financial Officer of Empire Blue Cross and Blue Shield. I execute this affidavit in support of the New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield's motions for a stay in these actions pending appeal.

2. Familiarity of this Court with the background information on the New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield, as well as the operation of these Plans as health services corporations, is assumed. *See* Affidavits of Antonini in Support of Cross-Motion for Summary Judgment ¶¶3-6; Weissman ¶¶18-23 and Reply Weissman Affidavit ¶¶3-8. Familiarity with the statutes at issue is also assumed.

DEFENDANTS WILL BE IRREPARABLY HARMED IF THE ORDER IS NOT STAYED

3. As set forth in the submission of the State, the Blue Cross and Blue Shield Plans, and the hospitals in support of their cross-motions for summary judgment, the differentials are integral

parts of the $20 billion hospital inpatient rate setting scheme in New York and these parties will be significantly harmed if the 13% differential is immediately enjoined. Moreover, loss of the differential will have an adverse impact on the continuance of the Blue Cross and Blue Shield community pools with potentially devastating consequences to the people of this State.

A. *Harmful Disruption of the Hospital Reimbursement System*

4. In actuality, and as recognized by this Court at pages 19-20 of the Opinion and Order, the potential ramification of this Court's decision is extremely broad and calls into question New York State's efforts to regulate and control hospital costs. The defendants have contended, in fact, that the Plaintiffs in these actions have actually challenged the right of the Legislature to establish a comprehensive reimbursement system that determines the reimbursement rates of all payors and controls the costs of hospitals.

5. It is beyond question that disruption of the integrated reimbursement methodology through the loss of the differential will necessarily adversely affect hospital financial stability which is one of the primary goals of the NYPHRM system.

6. Because all payors and all the hospitals have been operating under the NYPHRM system for more than a decade, it is extremely harmful and prejudicial for the system to be discarded overnight. While the appeals on these issues are pending, the *status quo* should be maintained to avoid confusion and disruption of the health care delivery system which has already commenced since this Court rendered its decision.

7. For example, since the decision, serious questions have been raised as to whether payors must continue to pay all other components of the state certified rate, without the differentials or whether payors have the option to pay charges or negotiated rates

in lieu of the state certified rates. This has caused and will cause chaos and confusion in the health care delivery system, as well as in the insurance marketplace.

8. If the differential is eventually held to be preempted by ERISA upon appeal, precious time to consider reimbursement alternatives will have been gained by a stay of this Court's decision. In such a manner, further exacerbation of hospital financial problems can be avoided which is obviously in the public's interest.

9. It also must be noted that if the Plans can no longer benefit from the differential in hospital reimbursement rates paid by payors, the Plans must consider making significant changes in the manner in which the Plans promote hospital financial stability. *See* Weissman Affidavit in Support of Motion for Summary Judgment ¶40. Whether advance payments in the amount of $300 million can continue under a system without the differential is under consideration. Loss of advance payments would be disastrous to hospitals.

10. Recognition of the broad ramifications of this decision, as this Court has done, should lead the Court to conclude that maintenance of the present highly integrated health and insurance systems, including the differential, is necessary for a time during the pendency of the appeal.

11. The loss of the differential as part of hospitals' reimbursement will cause grave, immediate, financial consequences for the hospitals and will affect the Plans' subscribers ability to obtain access to quality medical care as loss of the differential will undoubtedly affect the level of services provided by hospitals. The hospitals will lose approximately $160 million in operating income that they were entitled to receive under the current NYPHRM system which does not expire until the end of this year.

See Sisto Affidavit in Support of Cross-Motion for Summary Judgment, ¶¶39-42.

B. *Direct Impact on Plans' Ability to Continue to Spread Risk*

12. In the Opinion and Order, the Court found that the payment of the differentials by commercial insurers increases the numbers of good risks in the Blue Cross and Blue Shield pools, thereby providing for the spreading of high risk individuals among a larger pool. Opinion and Order, page 23.

13. Encouraging the spreading of risks is an extremely important function of the differentials. Without the 13% differential, the Plans, their subscribers and the people of the State of New York will be irreparably harmed, especially in light of the fact that no replacement system is available at present.

14. As noted by the Deputy Superintendent of Insurance James Clyne:

> [i]f the differentials are eliminated or reduced, the Blue Cross Plans would not be in a position to make coverage available to those least able to obtain it and the government, through tax monies, would become the insurers of last resort through Medicaid or by subsidizing hospitals directly.

Clyne Affidavit ¶9.

15. Deputy Superintendent Clyne also described the spiraling effect the loss of good risks to commercial insurers offering lower premiums has on the Plans community rated pools—as good risks leave, the community pools dwindle resulting in higher premiums for the remaining subscribers. This cycle, he explained, is offset through the differentials which restore "some measure of equality" to the insurance market-place by making

Blue Cross more attractive to good risk groups seeking lower payments to hospitals.

> Were it not for differentials, the inability to attract good risk customers would result in a smaller and smaller risk pool, comprised of predominantly poorer risks causing higher premium rates and deterioration of a viable health insurance system.

Clyne Affidavit ¶19.

16. There is uncontroverted proof in the record that a large percentage of the groups which leave the Plans' pools are good risk groups which leave to obtain commercial coverage at a lower premium. *See* Reply Affidavit of Weissman at ¶¶13-15.

17. If during the pendency of the appeals in these actions, the commercial insurers are no longer required to pay the differentials, the commercial insurers' ability to cherrypick good risks from the Plans' pools is greatly enhanced.

18. In fact, since Chapter 501 of the Law of 1992 was enacted, cherry picking has accelerated. *See* Weissman Reply Affidavit in Support of Cross-Motion for Summary Judgment ¶¶17-18. There is an ever increasing percentage of high risks in the community rated pools than ever before which will require premiums to continue to be increased at higher rates to avoid huge losses.

19. On January 1, 1993, Empire was granted an overall weighted average increase of 25.5% on its community rated contracts. Even with the increase, Empire projects that it will lose *$143,000,000* on these contracts during 1993. A copy of a portion of the Superintendent's Opinion and Decision granting the increase is attached hereto. The losses on these contracts will greatly increase without the differentials in hospital reimbursement rates as greater numbers of good risks leave to obtain

coverage from commercial insurers which are no longer required to pay higher hospital rates, according to the Court's decision.

20. The existence of the community rated pools of the Plans, containing an ever increasing number of high risk subscribers, are directly threatened by the loss of the differential as recognized by the Insurance Department. This would directly result in higher numbers of uninsured in New York State. *See* Weissman Affidavit in Support of Motion for Summary Judgment ¶38.

21. The impact the loss of the differential will have on the Plans' business other than on community rated contracts cannot be understated. The Plans compete with commercial insurers in the large group market so that the rates on these contracts can subsidize the community rated contracts. This permits the community rated coverage to be offered at an affordable rate. Without the differentials, the Plans' ability to compete in the large group market will be adversely affected threatening the subsidies provided to the community rated subscribers and the affordability of rates, thereby potentially increasing the risk of pricing insurance out of reach for many more individuals and Medicare supplementary coverage subscribers. *See* Reply Affidavit of Weissman, ¶¶6-8.

22. It is in the public interest and in the interest of the Plans and the hospitals to allow the current system to operate during the pendency of this appeal.

C. *Harm to the Commercial Insurers*

23. In contrast to the overwhelming disruption and harm caused to the Defendants if a stay is not granted, the Plaintiffs would simply be required to pay a differential, as they have been doing for a decade. If the Plaintiffs are successful on appeal, adjustments to future hospital rates paid by the commercial insurers could be simply made.

24. The Plaintiffs harm is clearly outweighed by the harm which will be caused by the immediate disruption of the operation of the health care and insurance systems if a stay is not granted.

WHEREFORE, the Intervenors respectfully request a stay of this Court's Opinion and Order during the pendency of the appeals in this action.

JERRY WEISSMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Daniel Sisto, filed _____

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Daniel Sisto, being duly sworn, deposes and says:

1. I am President of the Intervenor Hospital Association of New York State ("HANYS"). In this capacity, I am required to be fully familiar with the operation and circumstances of hospitals throughout New York State, including the importance to them of the 13% differential as operating income and the consequences of its loss. This Affidavit is submitted in support of HANYS' motion for a stay of this Court's Order of February 3, 1993 enjoining the enforcement of the 13% differential.

2. My knowledge of the consequences that will befall hospitals throughout the State is derived from a number of sources. First, HANYS regularly collects financial data from each of its member hospitals. This information is continuously analyzed by HANYS staff and reviewed by me and other HANYS management on an ongoing basis. Second, many studies by outside agencies and experts on the financial condition of hospitals are prepared every year. These are also collected and reviewed by myself and HANYS staff. Third, as president of HANYS, I meet or speak virtually daily with the Chief Executive Officers and Chief Financial Officers of our member hospitals, during which the financial difficulties and circumstances of hospitals are reviewed.

These can be formal meetings such as Board of Trustees meetings or sessions of the Council on Health Care Financing, or informal communications such as telephone conversations wherein hospital executives relate to me the consequences of events, such as the invalidation of the 13% assessment.

3. While the Court may be accustomed to reading what it considers to be hyperbole by parties claiming irreparable injury, I assure the Court that it is very difficult to overstate the harm that will be caused to hospitals and the public by a loss of the revenues from the 13% differential for even the briefest period. For 1991, the last year for which complete data is available, the 13% differential accounted for approximately $.60 million in operating income to hospitals statewide. The best estimates for the current impact of the 13% differential is about $200 million. The precipitous removal of this revenue source, before the appeal can be heard or the Legislature can attempt a reconfiguration of the hospital inpatient reimbursement system, will cause serious and irreparable injury to hospitals and the consuming public.

What we can expect to see very shortly would include hospital defaults on mortgage payments, cancellation of plans for purchase of state-of-the-art equipment and capital construction or renovation projects, breach of collective bargaining agreements, large-scale layoffs, closure of hospital programs and services, the simple inability to meet hospital short-term financial obligations, and, as a result, a serious decline in the availability of hospital services of the highest quality.

THE FINANCIAL CONDITION OF NEW YORK STATE HOSPITALS

4. As mentioned previously, numerous studies have been made of the financial condition of New York State's hospitals by HANYS, as well as by independent examiners. Those studies have consistently concluded that New York's hospitals experi-

ence dangerously low operating margins and a financial condition which is very weak, both from an objective standpoint and relative to hospitals across the United States. Rather than just cite a few individual instances of harm that particular hospitals will suffer, in order to avoid any suggestion that such claims are aberrational or merely anecdotal, I will relate the findings of two recent independent studies which confirm on a system-wide basis our hospitals' deteriorating and perilous financial condition.

5. Health Care Investment Analysts, Inc. (HCIA) recently conducted a study of the financial condition of New York's hospitals. HCIA is a nationally-recognized source for health care information and conducts numerous studies both for government and private associations. HCIA's database is probably the most extensive in the country and its analytical membership consists of members of the Johns Hopkins University faculty. HCIA analyzed various statistical indicators to arrive at certain conclusions regarding the economic condition of the hospital system in New York as of the end of 1991. A copy of the HCIA study has already been forwarded to the Court and the parties.

6. HCIA observed that "[b]ecause hospital inpatient reimbursement for all payers (Medicare, Medicaid, Blue Cross, Commercial Insurers, and Self-Pay) is regulated by either the State or Federal governments of New York, the financial health of New York hospitals is significantly affected by changes in public policy. Thus, players in the industry must be aware of the financial condition of New York hospitals and be sensitive to the relationship of policy to the fiscal viability of hospitals," (HCIA study, p.9). This observation is particularly relevant to the matter at hand, since elimination of the 13% differential, due to ERISA preemption, amounts to a major deviation in policy that will withdraw an estimated $200 million from our hospitals.

7. Using an analysis of 21 selected indicators of financial and operating performance, HCIA grouped hospitals into one of four

classifications: Critical, Poor, Adequate, and Good. The "Good" rating is considered investment grade, and it is expected that hospitals in the "Good" category should be able to raise debt financed capital based on their historical performance. The "Adequate" category consists of hospitals which may, under some circumstances, be able to raise debt finance capital, while those in the "Poor" category are those in which performance has deteriorated more rapidly than expected during the last 5 years. Finally, those in the "Critical" category are those in the most desperate financial condition and are on the verge of bankruptcy or closure without a substantial infusion of external support. (HCIA study, p.3).

8. The HCIA study shows that 53% of New York's nonprofit hospitals are either in the "Critical" or "Poor" categories, 42% are in the "Adequate" category, and only 5% are considered "Good." (HCIA study, p.4). In the New York City area, among the non-teaching hospitals (those which do not have interns and residents), 37% were in "Critical" condition, 37% were in "Poor" condition, only 26% were considered "Adequate," and none were "Good." Similarly, teaching hospitals in the downstate area showed 22% in "Critical" condition, 43% in "Poor" condition, 27% deemed "Adequate," and 8% labeled as "Good." Statewide, of the six groupings of hospitals used for reimbursement purposes, four of the six peer groups experience serious financial hardships, with well over half of all of the facilities in these four groups classified as being in either "Poor" or "Critical" condition. (HCIA study, p.5).

9. The HCIA study also observed that New York hospitals placed 49th out of 51 states (including the District of Columbia) in terms of operating profitability, a position unchanged from 1987.(HCIA study, p.8) HCIA further concludes that since its previous study three years ago, the overall performance of New York's nonprofit hospitals has continued to deteriorate, with the

number of hospitals classified as "Poor" or Critical" increasing substantially since 1988. (HCIA study, p.9).

10. A second study was recently conducted by William O. Cleverley, Ph.D., CPA. Dr. Cleverley is a Professor at Ohio State University, is an acknowledged expert in hospital reimbursement matters, and is a frequent publisher of studies of various states' hospital reimbursement performance. Dr. Cleverley's report, which has also been provided to the Court and the parties, examined financial information for nearly all New York State hospitals for the period 1989 through 1991 and compared New York State hospital performance with that of hospitals across the country. Four basic financial concepts were analyzed to measure the strength of hospital performance; profitability, liquidity, debt capacity, and condition of physical facilities. The general conclusion of the report is that

> the overall financial condition of NYS hospitals is very weak when compared to U.S. hospital industry averages and to generally accepted standards of financial performance. Without substantial improvement in NYS hospital financial performance in the near future it is our opinion that many NYS hospitals will face severe financial problems with the possibility of significant increases in closure and bankruptcies. It is also very likely that the physical and technological condition of hospital plant facilities will deteriorate in NYS, making many NYS hospitals substandard providers of health care services relative to U.S. hospital standards. (Cleverley study, p.2).

Significant among Dr. Cleverley's general observations is that expectations regarding hospital payments over the next few years are almost universally negative as government and major private payors seek to reduce their health care expenditures. He concludes; "With the already weakened financial position of many

NYS hospitals, the resulting shock could prove fatal to many hospitals in NYS." (Cleverley study, p.3).

11. I will not prolong this Affidavit with a detailed explanation of all of Dr. Cleverley's findings. However, I believe it is important to highlight one aspect of his study which is of more immediate concern and particular relevance to the matter at issue. This is with regard to short-term liquidity of our hospitals.

Dr. Cleverley uses two typical financial ratios to measure liquidity:

1. Current (CUR) Ratio; and

2. Days Cash on Hand (DCOH) Ratio.

CUR ratios for New York State hospitals are very low when compared to United States hospital medians. The median New York State CUR ratio in 1991 was 1.19 compared to the U.S. hospital median of 2.00. According to Dr. Cleverley, no New York State group of hospitals has a median that matches the U.S. median, and several groups are less than 1.0. A current ratio less than 1.0 means that the hospital does not have enough short-term cash and receivables, as well as other designated current assets, to meet obligations that will be due in the very near future. More than 25% of all New York State hospitals were in this situation at the end of 1991, according to Dr. Cleverley's report. (Cleverley study, p.10).

12. As to cash on hand (the DCOH ratio), median values for New York State hospitals are also very low. In 1991, the median DCOH across New York was 13.6 days, compared to an all U.S. median of 19.6 days. Dr. Cleverley indicates that "[t]hese lower values would be of less concern if NYS hospitals had sufficient amounts of long term reserves available to meet short term needs should an unexpected event take place, but this is not the case."

(Cleverley study, p.10). Dr. Cleverley notes that long-term reserves of New York State hospitals are very low and thus are not available to meet short-term needs to meet an unexpected event. The "unexpected event"—elimination of $200 million in revenue—has occurred and our hospitals do not have the cash or long-term reserves to cushion this blow. Even more extraordinary than the median 13.6 DCOH is the study's report that New York City hospitals are in a very dangerous position, with more than 25% of all hospitals in the New York City area having fewer than 5 days cash on hand. (Cleverley study, p.10).

A hospital with so little available cash is, quite frankly, in desperate need of continuously flowing dollars. Cash on hand is what funds employee payrolls and pays suppliers of services. In a service-intensive sector such as hospital care, a missed payroll is an invitation to disaster. Unpaid staff do not, under any circumstances, provide optimal patient care. Without the continued flow of the differential dollars, hospitals' ability to maintain service continuity, especially in those areas where severe cash shortages are widespread, is directly and immediately jeopardized.

13. Had this information from the HCIA and Cleverley studies emanated solely from HANYS, it might be dismissed as self-serving aggrandizement. The studies and conclusions, however, have come from national experts on hospital financing who have consistently reported the precarious condition of hospitals across the State. Unfortunately, final data after 1991 is not currently available, but the consistent trends indicate that the precarious state of our hospitals is continuing unabated. With extremely low and negative operating margins, extraordinarily high debt ratios and a precarious cash-on-hand situation, the harm to cash flow caused by the immediate removal of $200 million in operating income will substantially disrupt hospital operations, both short-term and long-term.

REVENUE FROM THE DIFFERENTIAL IS NEEDED TO MAINTAIN CURRENT OBLIGATIONS

14. Hospital financial and contractual commitments exert a constantly upward pressure on hospital costs, at a time when financial stability is most fragile. It is obvious that hospitals require continued operating revenues in order to maintain services and it is further obvious that any diminution in revenues, given the financial fragility of New York's hospitals, has the very real potential of seriously disrupting operations.

15. For example, hospitals, like many other service enterprises, have a high percentage of their expenses dedicated to employee salaries. For a large number of hospital employees, particularly in the downstate sector of the State, employee salaries are collectively negotiated in long-term contracts. By necessity, these negotiations and resulting collective bargaining agreements are premised on projections of expected revenues which will be sufficient to cover agreed-upon salary and fringe benefit increases.

16. In 1992 in particular, a major contract was negotiated between approximately 30 hospitals in the New York City area and the union representing about 38,000 non-professional hospital employees, such as laundry workers, housekeepers, nurses aids, secretaries, laboratory technicians, dieticians, and respiratory therapists. The terms of the contract cover a 3-year period from mid-1992 through mid-1995. For each year, there are salary and fringe benefit increases. The contract calls for an increase in 1993, which on average amounts to some $2,000 per employee, for a total of about $78 million. This sum is an increase over the percentage increase in 1992 and will be followed by an additional increase in 1994. These binding salary obligations were obviously reached on the expectation by the hospitals that revenues would be sufficient to cover the increased contract costs, based upon continuation of present revenue sources. While the 13%

differential will not provide all the revenue to support the contract increases, loss of this revenue will jeopardize or preclude these hospitals' ability to fulfill their contract obligations.

17. This problem relates not just to regional collective bargaining agreements or to non-professional employees. Many other contracts, more typically negotiated on a hospital-by-hospital basis, apply specifically to registered professional nurses, of which there is a tremendous shortage. In the case of professional nurses, negotiated agreements have resulted in percentage increases which in general have exceeded those for non-professional employees. Furthermore, this phenomenon does not exist solely in the New York City area, but is experienced by all hospitals throughout the State. Hospitals are contractually bound to pay employees according to the contract terms and on regular paydays. The inability to meet these commitments will result in more than just labor strife. These professionals, who are in critically scarce supply, will simply leave the hospital or the State for better job stability elsewhere. The revenues derived from the 13% assessment are required in order for hospitals to be able to attract and retain adequate numbers of employees so that services to patients continue uninterrupted.

As I previously acknowledged, the revenues from the 13% differential are not the sole source for supporting employee salary requirements, but certainly the daily cash flow from the $200 million is essential to almost every hospital's ability to make payroll. Without the $200 million or an alternative source immediately available to make up for this loss of funds, the provision of hospital services will no doubt suffer.

18. Another problem of equal magnitude that will be caused by the loss of the 13% differential will be the inability of hospitals to make mortgage payments. As the HCIA study indicates, the investment quality of New York hospitals is already precariously low and the prospect of removing a significant portion of

expected revenues will undoubtedly trigger foreclosures. Due to the already acknowledged difficulty of New York hospitals' ability to make mortgage payments on construction projects, the federal Department of Housing and Urban Development is seriously considering closing the New York market for its FHA insurance program. This is particularly troublesome since the vast majority of hospital construction projects are now FHA insured because the conventional market is for all intents and purposes inaccessible to New York hospitals.

19. In addition to collective bargaining agreements and mortgage obligations, there are a myriad of day-to-day operational demands which consume resources that must be supported by adequate daily revenues. These day-to-day operational demands have a direct bearing on patient care. The purchase of supplies and equipment; waste disposal; the purchase of vaccines and the continuation of immunization programs for childhood disease; the need to address the huge and increasing demands to treat the epidemics of tuberculosis, AIDS, substance abuse and mental illness all require that sufficient revenues be in place.

20. Ultimately, it is the public at large that will suffer the most from immediate loss of the 13% differential. When a workforce is reduced, or fewer supplies are purchased, or construction is stalled, then patient care is affected. This affects all patients, including the plaintiffs' insureds or beneficiaries. This is not a consequence that can be fixed at some later time, because the patient who receives inadequate care today cannot be "compensated" by better care tomorrow when the system has stabilized. Thus, should the differential be eliminated with no opportunity for an alternative to be developed, irreparable harm will befall not just the hospitals, but also the consuming public.

The Court can be assured that wholesale patient care disruption will be avoided whenever possible, since direct patient service reductions is a solution of last resort. This result is unavoidable,

however, in those hospitals which are already at the breaking point. What will uniformly occur will be a less measurable, but equally insidious phenomenon. Staffing will be shaved—not completely eliminated—in certain clinical units or hours in outreach clinics will be reduced or appointments canceled and rescheduled for weeks later. Patients' chronic conditions will worsen; long waits for the overtaxed floor nurse will get even longer; laboratory results will arrive a day later. Cumulatively, the quality of care across the system will degenerate. The immediate removal of the differential funds hastens the degeneration because, across the State's hospital system, there are not reserves to substitute for these revenues.

21. In order to measure the impact of the immediate loss of the 13% differential in practical terms, my staff contacted two hospitals, one downstate (Brookdale Hospital Medical Center) and one upstate (Ellis Hospital). The Brookdale Hospital Medical Center is a 796 bed hospital in Brooklyn. Brookdale serves a heterogeneous patient population which includes significant numbers of patients enrolled in employee benefit plans. The Medical Center is also categorized by New York State as a "financially distressed" hospital, meaning that its financial condition is especially precarious and that it is a crucially needed source of health care in the community.

Virtually all of Brookdale's employees—nurses, therapists, technicians, clerks, etc.—are unionized and covered by an existing collective bargaining agreement. That agreement requires the hospital to make designated contributions to its employees' health and welfare benefit fund. It is my understanding that immediate removal of the 13% differential revenue is likely to cause the Medical Center to fall into delinquency on its payment obligations. In addition, I also understand that without the revenue specifically attributable to the 13% differential, the Medical Center may be unable to make the next required payment of its hospital malpractice insurance premium. This raises the startling

prospect of the hospital's loss of insurance coverage which, even if this were to occur for some limited time period, would expose it to severe liability risks.

22. Ellis Hospital is a 352-bed hospital located in Schenectady. In 1992, Ellis suffered operating losses of over $6 million. By restructuring management, laying off workers, and eliminating job positions, the Hospital's budget for 1993 is at break-even. Ellis' patients include a sizeable number covered by employee benefit plans, and Ellis derives over $550,000 from the 13% differential alone. Thus, the loss of the differential would bring the hospital back into an operating deficit situation. The $550,000 in revenue supports about 20 full-time equivalent positions at Ellis. I am advised that the hospital has not reached a conclusion regarding how the loss would be apportioned, but a variety of measures are under consideration. These include limiting or eliminating the operation of outreach clinics in the City of Schenectady and outlying areas of Schenectady County, reducing the hospital's outpatient mental health program and reducing its inpatient psychiatric program. Due to prior years' revenue shortfalls, Ellis has already been forced to discontinue its alcoholism program and its poison control program. I understand that in a typical year, the hospital considers $4 million in requests for new equipment, yet normally is only able to afford about $1 million in new purchases. A further revenue loss would mean even less availability of more sophisticated diagnostic and treatment equipment.

With regard to medical supplies for hospitalized inpatients, such as drugs, Ellis is presented with a very common dilemma. The drug of choice by physicians for the early stages of heart attack is TPA. TPA costs about $2,200 per dose. The expected 1993 cost to Ellis of TPA alone is about $270,000. The revenue needed to purchase the drug is at least in part derived from the differential.

With a budget at break-even, the $550,000 loss in 13% differential revenue will, I believe, directly affect patient care at Ellis. I cannot predict exactly where or how the impact will be felt—whether by a combination of reduced clinic hours, elimination of some psychiatric beds or unavailability of the preferred heart attack medicine or more drastic cuts in just one area—but the hospital, staffed as it is, must as a last resort look to patient care services for cuts.

23. I do not suggest that the 13% differential should be extended indefinitely despite the Court's February 3 holding. I do respectfully represent, however, that it is vitally important that the differential not be precipitously eliminated without the chance for one of two things to occur: either that the Second Circuit have the opportunity to review this Decision or that the State Legislature have the opportunity to restructure the system for hospital reimbursement to account for the voiding of the differential. Neither of those events can occur immediately. The issue is not solely a matter of losing funds; it is also the quality and extent of hospital care throughout the State. Our all-payor regulated reimbursement system cannot, as it is now constructed, be administratively adjusted to accommodate this Court's decision immediately. We simply ask that the Court recognize this reality and allow for some period of time for either appellate review of this matter or some other action to be taken to address the serious and far-reaching consequences of the Court's decision. I respectfully urge that the Court consider the real and difficult circumstances which are arising immediately and provide hospitals with the requested relief, therefore minimizing the disruption and damage to the hospital system and to our patients.

DANIEL SISTO

[Jurat omitted in printing.]

IN THE
UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF NEW YORK

Affidavit of Timothy F. Lyons, filed February 9, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

TIMOTHY F. LYONS, being duly sworn, deposes and says:

1. I am employed by plaintiff The Travelers Insurance Company ("The Travelers") as Counsel in the Law Department of The Travelers. I have been responsible for overseeing this lawsuit since it was commenced in June of last year.

2. I submit this affidavit in opposition to the Defendents' and Intervenors' motions for a stay of the injunction which this Court entered on February 3, 1993. In this affidavit, I specifically address the issues relating to the 11% surcharge and the 13% surcharge. Although I believe the same logic applies to the 9% surcharge, I do not address that matter in this affidavit since The Travelers Insurance Company did not assert a claim as to the 9% surcharge.

THE 11% SURCHARGE

3. I would like to first turn my attention to the 11% surcharge. This surcharge was enacted as part of New York's Omnibus Revenue Act of 1992, effective April 1, 1992, for a one-year period in order to balance New York State's budget. By law, the 11% surcharge will expire on March 31, 1993.

4. Since the 11% surcharge was first enacted in April 1992, The Travelers has segregated the funds relating to the 11% surcharge. The Travelers' reason for doing this is simple: Upon analysis of the statute, The Travelers realized that if it paid the surcharge, it would never be able to recover the amounts at issue even if it prevailed on its legal challenge to the surcharge. In essence, the statute requires The Travelers to pay the 11% surcharge to the hospital rendering the service, which in turn, must pay the funds at issue over to New York State. Thus, for The Travelers to recover the amounts at issue, The Travelers would have to bring lawsuits against each of the approximately 260 hospitals operating in New York State. Of the approximately $9.1 million which The Travelers anticipated paying as a result of the surcharge, this would result in an average claim against each hospital of approximately $35,000. Inevitably, in such lawsuits, the hospitals would defend on the grounds that The Travelers had voluntarily paid the amounts at issue, and that The Travelers should seek recovery from New York State, the ultimate recipient of the funds at issue. (The State, of course, maintains that The Travelers' remedy is against each individual hospital (The State Defendents' Memorandum in Support of a Stay at 7).) Even if The Travelers could overcome these defenses, The Travelers would then have to enforce judgments against 260 separate hospitals. Given the cost of such a sweeping litigation program, and the difficulties of enforcing a money judgment against a hospital, The Travelers recognized that unless it withheld all funds relating to the 11% surcharge, its challenge to the statute would be futile.

5. The same is true today. If The Travelers were now compelled to pay the 11% surcharge, there would be no practical way for it to ever recover the monies at issue. In other words, The Travelers would be irreparably injured if it had to pay the 11% surcharge. The State, of course, faces no such injury. If this Court denies the motion for a stay, The Travelers will continue to segregate all amounts relating to the 11% surcharge. In the unlikely event this Court's decision is reversed and the 11% sur-

charge is upheld, The Travelers will turn the funds at issue over to the State. Thus, if the surcharge is upheld, the State will be able to immediately recover the funds at issue. However, if The Travelers now pays the amounts at issue, and Defendants or Intervenors do not obtain a reversal of this Court's ruling on the 11% surcharge, The Travelers would not be able to recover the amounts at issue.

6. In closing my discussion of the 11% surcharge, I note that I am quite surprised by the State's claim that it will be irreparably injured if this Court enjoins the enforcement of the 11% surcharge. In the ten months since the enactment of the 11% surcharge, the State has done absolutely nothing to enforce the surcharge. In fact, the State has never even contacted The Travelers Insurance Company and requested that the 11% surcharge be paid. In light of the State's acquiescence in our withholding of the 11% surcharge and the fact that the 11% surcharge will expire on March 31, 1993, it is hard to imagine how the State will be irreparably injured if the surcharge is not enforced for the remaining seven weeks of its life.

THE 13% SURCHARGE

7. Unlike the 11% surcharge, the 13% surcharge has been in place for several years. Although The Travelers recognized at the time it commenced this litigation that recovery of amounts paid pursuant to the 13% surcharge would also be unlikely for the reasons discussed with regard to the 11% surcharge, The Travelers did not want to disrupt the functioning of New York's hospital system before obtaining a ruling on the legality of the 13% surcharge. Therefore, it continued to pay the 13% surcharge during the pendency of this litigation in order to give the State an opportunity to make alternative plans for the funding of New York's hospital system should this Court determine, as it has, that the 13% surcharge is invalid under ERISA.

8. The 13% surcharge applies in the case of both self-insured and fully insured ERISA plans. With regard to the 4,338 ERISA plans as to which The Travelers provides health insurance, The Travelers estimates that it has paid $7.2 million as a result of the 13% surcharge since this lawsuit was commenced in June 1992. As explained in the Gutterman and Sujecki affidavits submitted in support of The Travelers' motion for summary judgment, the 13% surcharge is reflected in the premiums charged by The Travelers.

9. Since this lawsuit was commenced in June 1992, the 91 self-insured ERISA plans with regard to which The Travelers provides administrative services have paid approximately $8.6 million as a result of the 13% surcharge. In sum, as a result of the 13% surcharge, The Travelers has paid a total of approximately $15.8 million on behalf of 4,429 ERISA plans since this lawsuit was commenced in June 1992.

10. The total cost of the 13% surcharge for the plans at issue is approximately $2.0 million per month. I understand that it would normally take approximately eight months for the briefing, argument and decision of an appeal of a case such as this one. Thus, if this Court were to stay its injunction pending appeal, the ERISA plans at issue would probably pay an additional $16.0 million pursuant to the 13% surcharge. It would simply be unfair to ask the ERISA plans to bear this burden in light of the fact that there is no practical way for the plans to recover the funds at issue.

11. The Travelers fully understands the need to finance New York's hospital system. However, ERISA plans operating in New York State should not be asked to continue to subsidize the hospital system at the rate of two million dollars a month through an unfair surcharge which this Court has determined to be illegal under ERISA. This is particularly true since those plans have already paid approximately $15.8 million since this litigation was commenced.

12. In this regard, I note that The Travelers is not even in a position to continue paying the surcharge with regard to its self-insured ERISA customers. Under ERISA, the plan sponsors, trustees or other appropriate fiduciaries have an obligation to use plan funds only for the benefit of plan participants and beneficiaries. Recognizing the serious legal issues raised by the 13% surcharge, it is extremely likely that the plan sponsors, trustees or other appropriate fiduciaries of many of the self-insured plans will simply refuse to continue to pay the 13% surcharge. This, in fact, has already occurred with regard to two self-insured plans. In late 1992, The Travelers was informed by representatives of the two self-insured plans at issue that the plans had determined that the 13% surcharge was illegal under ERISA. The Travelers was, therefore, instructed not to use any plan assets to pay the 13% surcharge. Clearly, ERISA plans have felt the burden of the 13% surcharge and feel they cannot continue to pay the surcharge.

13. In light of this Court's determination that the 13% surcharge is illegal under ERISA, and the inability of either The Travelers or an ERISA plan to recover funds paid pursuant to the 13% surcharge, this Court should not stay its order enjoining enforcement of the 13% surcharge. During the pendency of an appeal from this Court's February 3, 1993 order, The Travelers will segregate the funds relating to the 13% surcharge in connection with its fully insured ERISA customers. The Travelers will also recommend that its self-insured ERISA customers do likewise. Thus, in the unlikely event that this Court's decision is reversed and the 13% surcharge is upheld, the funds will be readily available for payment to the hospitals. This will leave the hospitals with an easy mechanism to recover the funds at issue. In closing, I note that none of the Defendants or Intervenors have proffered any kind of similar mechanism for the reimbursement of the funds relating to the 11% surcharge or the 13% surcharge to The Travelers or the ERISA plans at issue.

WHEREFORE, the defendants' motion to stay the injunction entered by this Court on February 3, 1993 should be denied.

TIMOTHY F. LYONS

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Steven C. Anderman, filed February 19, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

STEVEN C. ANDERMAN, being duly sworn, deposes and says:

1. I am a Deputy Director of the Office of Health Systems Management ("OHSM"), New York State Department of Health ("Department"). I have supervisory responsibility over OHSM's Division of Health Care Financing, including the hospital reimbursement rate setting process, and I am accordingly familiar with the facts hereinafter set forth. I make this affidavit in support of defendants' application for a stay of Judge Freeh's decision and order of February 3, 1993 in the instant case, pending defendants' appeal of said decision and order to the Circuit Court of Appeals for the Second Circuit.

2. Judge Freeh's decision largely invalidated three provisions of §2807-c of the New York Public Health Law ("NYPHL"): (a) the 13% differential hospitals are generally required to apply to the inpatient hospital bills of patients covered by third party payors other than Medicare, Medicaid, health maintenance organizations ("HMO's"), and/or Blue Cross plans (NYPHL §2807-c(1(b)), (b) the additional 11% differential hospitals are required to bill for patients covered by commercial health insurance carriers (NYPHL §2807-c(11)(i)), and, (c) the contingent variable differential (0% to 9%) applicable to patients covered by HMO's

(NYPHL §2807-c(2-a)). This affidavit will address the issue of the 13% differential, the abrupt invalidation of which will have a significantly disruptive effect on New York's system for financing hospital inpatient care. It is therefore respectfully submitted that, under these circumstances, a stay pending appeal of the Court's decision and order is warranted.

3. There are approximately 260 hospitals in New York, annually providing over 21 million days of inpatient care. Virtually all of the revenue these hospitals receive for inpatient care, with the exception of Medicare reimbursement, is regulated pursuant to NYPHL §2807-c. The reimbursement system reflected in this statute is highly integrated and is carefully designed to achieve the critical policy goals of assuring access to high quality hospital care, maintaining hospital fiscal integrity and promoting efficiency and cost containment.

4. The 13% differential is an important element in this integrated reimbursement system. It provides significant revenue to hospitals and is of critical importance in maintaining the competitive viability of the Blue Cross system. The hospital reimbursement and health insurance system cannot long function in its current form without the 13% differential. Therefore, the State will have to revise the hospital reimbursement system in some fashion as a result of this Court's decision and order.

5. The invalidation of the 13% differential will reduce hospital revenue by approximately $200 million a year. Virtually every hospital in New York will be affected. There is no methodology currently in place which would permit the hospitals to replace this revenue. The abrupt and unplanned for loss of $200 million in inpatient revenue will have a disruptive impact on the hospital system. It is essential that hospitals and the State hospital regulatory system have sufficient time to properly evaluate the impact of this alteration of a significant element of the hospital reimbursement system and to consider what adjustments in the system

will be required. A stay pending appeal will permit such an evaluation to be conducted in a reasoned, deliberate manner. Absent that, any such evaluation and adjustment will necessarily have to be accomplished in haste, in an atmosphere of crisis that will not be conducive to the proper operation of a critical public resource.

6. The abrupt invalidation of the above-described provisions of NYPHL §2807-c will risk provoking a major crisis in the hospital system which the people of this state depend on for medical care. It is essential that if adjustments must be made in a health care system this large and complex sufficient time must be afforded to intelligently design the necessary changes.

WHEREFORE, it is respectfully submitted that defendants' application for a stay pending appeal of the Court's decision and order February 3, 1993 should be granted in all respects.

STEVEN C. ANDERMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Stuart L. Lefkowich, filed February 19, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

STUART L. LEFKOWICH, being duly sworn, deposes and says:

1. I am employed by the New York State Department of Social Services (Department) in the position of Assistant Commissioner. I serve as Director of the Bureau of Primary Care, Division of Health and Long Term Care. I am responsible for policy implementation relating to health maintenance organizations (HMO's) and managed care in the Medical Assistance (Medicaid) Program, established pursuant to Title 11 of Article 5 of the Social Services Law (SSL), Chapter 55 of the Consolidated Laws of New York.

2. I make this affidavit in support of Defendants' application for stay of the Court's order in this action.

3. In a previous affidavit in this action, sworn to September 30, 1992, I described in detail the joint federal-state Medicaid Program, the role of the Department in supervising administration of Medicaid, the provisions of federal and State law authorizing participation of HMO's and inclusion of managed care programs in Medicaid, the significance of HMO's and managed care in improving quality, continuity and comprehensiveness of health services under Medicaid, ant the important effect of the 9%

factor, imposed effective April 2, 1992 by subdivision 2-a of Section 2807-c of the Public Health Law upon rates of payment to general hospitals for reimbursement of inpatient hospital services furnished to subscribers of HMO's, as an incentive to HMO's to participate as managed care providers in the Medicaid program. Please refer to my earlier affidavit for a full exposition of these matters.

4. A significant increase in the number of HMO's participating in Medicaid was seen in 1992, the year of enactment of subdivision 2-a. In 1991, there were 13 HMO's with Medicaid contracts while in 1992, to the date of my earlier affidavit, 23 HMO's had Medicaid contracts.

5. Analysis of data becoming available in the months subsequent to my earlier affidavit demonstrates a more striking correlation between the effective period of subdivision 2-a and increased HMO participation in Medicaid. On April 1, 1992, immediately preceding the effective date of subdivision 2-a, there were 24 Medicaid contracts in effect with HMO's. On February 1, 1993, there were 47 such contracts with an additional 48 contracts in development. The number of Medicaid recipients enrolled in HMO's increased 58.6% in the 10 month period subsequent to the effective date of subdivision 2-a.

6. To achieve the overall statutory goal of enrollment in Medicaid managed care programs of 50% of the non-exempt Medicaid population, approximately 1.1 million Medicaid recipients would have to be enrolled. To reach that goal by the year 2000, a net enrollment increase of approximately 10,000 Medicaid recipients per month would have to be attained, taking into consideration that some enrollees will become disenrolled for various reasons. While not all managed care enrollees will be enrolled in HMO's, HMO's continue to be, as pointed out in my previous affidavit, the primary source of case managed care in the Medicaid program. On April 1, 1992, Medicaid recipients were being enrolled

in managed care at a net increase of 3,000 persons per month. On February 1, 1993, the rate was 6,000 persons per month.

7. It is apparent from these enrollment statistics that the statutory enrollment goal cannot be achieved in a timely manner unless HMO participation in Medicaid continues to increase from the levels attained in the 10 month period subsequent to the effective date of subdivision 2-a.

8. As demonstrated by these figures, the 9% factor established under subdivision 2-a is a significant influence in the increased participation by HMO's in Medicaid since April 1, 1992. Elimination of the 9% factor without an alternative incentive in place would cause some HMO's either to limit their Medicaid participation or not to participate at all.

9. Based upon my experience with managed care, I believe that the improved quality, continuity and comprehensiveness in Medicaid health services to be achieved through increased HMO Medicaid participation would not be attainable as prescribed in the statutory scheme if the 9% factor is eliminated or additional time is not made available to develop a substitute incentive for HMO's and a substantial number of HMO's limit their participation.

10. The harm described in Paragraph 9 herein, that would result to the extension of managed care to a highly vulnerable and medically underserved population if a stay is not granted, could not be remedied even if the Court of Appeals were to rule in Defendants' favor.

By reason of the foregoing, the Defendants' application for stay of the Court's order in this action should be granted.

STUART L. LEFKOWICH

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Miriam A. Boggio, filed February 19, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Miriam A. Boggio, being duly sworn, deposes and says:

1. I am a Deputy Superintendent of Insurance and make this affidavit in support of the motion of defendants, Mario M. Cuomo, Governor of the State of New York, Mark Chassin, M.D., Commissioner of Health of the State of New York, Salvatore R. Curiale, Superintendent of Insurance of the State of New York, and Mary Jo Bane, Commissioner of Social Services of the State of New York ("State defendants") for a stay pending appeal.

2. By Opinion and Order ("Order") dated February 3, 1993, this Court enjoined the State defendants from enforcing the 13%, 11% and 9% surcharges in the N.Y. Public Health Law against any commercial insurers or health maintenance organizations ("HMOs") in connection with their coverage of Employee Retirement Income Security Act ("ERISA") plans (Order p. 34).

3. The Court's injunction against these surcharges should be stayed pending the State defendants' appeal to the Second Circuit Court of Appeals because the injunction may result in irreparable injury to the States' insurance and health care system. Addressing my comments particularly to the 11% surcharge, the Court's injunction, if not stayed, will frustrate the State's efforts to

moderate the premium rates charged by the Blue Cross plans to their individual and small-group subscribers which had been dependent on the differential applicable to commercial insurers. This will contribute to continued erosion of the plans' community-rated pools. Subscribers may be forced to either drop coverage or move to commercial insurers. Blue Cross plans will, as a result, continue to face underwriting losses. Blue Cross will not be able to be restored to the *status quo ante* if the State ultimately prevails because they will be deprived of good risks and have little or no likelihood of getting them back.

4. The Department exercises authority over health service corporations and insurers who sell health insurance. Non-profit health service corporations, such the Blue Cross plans, historically have provided open enrollment, meaning they accept all applicants regardless of health status, and other benefits to the public. They utilize community rating practices for individuals and small groups in which the same premium rate is set for all persons covered by a policy form based on the experience of the entire pool of risks covered by that policy, regardless of the age, sex, health status, or occupation of the individuals in the pool. In addition, Blue Cross also provides most of the Medicare supplemental coverage and makes advance payments to hospitals which give them financial stability. Commercial insurers, on the other hand, either do not provide insurance to individuals or small groups or require evidence of insurability, exclude certain conditions from coverage, or require additional premiums because of the higher risk involved. However, despite the availability of health insurance to individuals and small groups on a community-rated basis through open enrollment by the Blue Cross plans, the Blue Cross plans have experienced a reduction in the total number of individual and small group subscribers which results in ever upward pressure on rates.

5. The community-rated pools of the Blue Cross plans have eroded because commercial insurers who experience-rate and

exclude individuals because of health status and occupation are able to maintain lower premium rates and siphon off the best risks. Between 1987 and 1989, for example, Empire Blue Cross, the largest New York health services corporation, lost 110,000 direct pay subscribers and 440,000 group subscribers. Thus, the utility of the 13 percent differential in providing a "level playing field" to these corporations in their competition with commercial insurers which can selectively underwrite their risks was diminished. This resulted in a competitive disadvantage to Blue Cross and an inability to maintain a mix of high, low and average risks. In response, the Legislature enacted the Governor's proposed legislation which required open enrollment and community rating by commercial insurers in the individual and small group marketplace. That proposal is effective April 1, 1993 (Laws 1992, ch. 501). In addition, the 11% surcharge to the commercial insurers' hospital reimbursement rate was enacted as part of the Omnibus Tax Revenue Act (Laws 1992, ch. 55, § 348).

6. The 11% surcharge was enacted in recognition of Blue Cross' special situation and problems described above and in more detail in the Clyne affidavit. If Blue Cross' community-rated pools continue to lose enrollment and their rates continue to increase, health insurance coverage will be unaffordable and inaccessible to even more New Yorkers. To the extent commercial insurers' rates reflect the additional differential, the rates charged by the Blue Cross plans will be more competitive, and good risks, both individuals and small groups, are more likely to enroll in Blue Cross. That would result in moderation of the Blue Cross rates, making health insurance more affordable to New Yorkers.

7. On the other hand, if the 11% differential is enjoined, the intended effect of a more competitive insurance marketplace will be blocked. Any salutary impact the 11% has on preventing the continued erosion of the Blue Cross community pools will not occur. Continued erosion of these pools will result in increased

underwriting loss, threatened insolvency of Blue Cross plans, and requests for additional rate increases which, if granted, will result in individuals and small groups dropping coverage.

8. This injury is irreparable because the Blue Cross plans cannot be restored to the *status quo ante* if defendants prevail. The plans have no way of reducing their rates to lure back the better risks who are being siphoned off by commercial insurers. The Blue Cross rates will continue to go up and the competitive disadvantage they face vis-a-vis commercial insurers will be exacerbated. The intent of the community rating/open enrollment bill, which is effective April 1, 1993, is to spread the risks by requiring that commercial insurers have the same underwriting practices as Blue Cross and eliminate selection of risks in individual and small group markets. The period prior to the effective date of that law provides an incentive for commercial insurers to intensify their efforts to obtain good risks from Blue Cross. To the extent they are able to do so, their community rates will be lower than the Blue Cross plans, and Blue Cross will remain at a competitive disadvantage even after that law takes effect.

WHEREFORE, I respectfully request that the Court grant the motion to stay the order pending appeal.

MIRIAM A. BOGGIO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Kathryn Allen, filed February 22, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

KATHRYN ALLEN, being duly sworn, deposes and says:

1. I am the Executive Director of the New York State Health Maintenance Organization Conference and make this affidavit in opposition to the motion of the defendants and the intervenors New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield ("Blues") for a stay of this Court's Order and Opinion, dated February 3, 1993, insofar as the Order enjoins the enforcement of the 9% surcharge.

2. The New York State Health Maintenance Organization Conference is a not-for-profit corporation consisting of 27 health maintenance organizations ("HMOs") licensed to operate in and located throughout New York State. The HMOs in the Conference currently provide health care to more than 2.8 million people in New York. The twelve individual HMOs that also have intervened serve well over one million people in all parts of the State.

3. As Executive Director of the Conference, I am fully familiar with the operations of HMOs throughout the State. Prior to becoming Executive Director of the Conference, I was the Director of Marketing for Health Insurance Plan of Greater New York,

the largest HMO in the State and one of the oldest in the country. I also served as the Vice-President, Marketing, at Rutgers Community Health Plan in New Jersey.

4. Among my duties as Executive Director, I serve as the lead staff person for the Conference's Medicaid Subcommittee, comprised of representatives of all the HMOs in the Conference. The Medicaid Subcommittee meets six times per year to discuss methods for improving the ability of HMOs to serve the Medicaid population and to address special problems that arise with regard to such matters as contracting with counties, quality assurance standards, regulatory requirements and other issues unique to the delivery of health care through the Medicaid program. The Medicaid Subcommittee was formed more than three years ago.

5. I also have been designated by the Conference to serve on the Managed Care Policy Advisory Group. The Group was formed at the request of the Conference and is comprised of representatives of the State Department of Social Services, the State Department of Health, the State Department of Insurance, the Counties of New York State, including New York City, the HMOs and other managed care providers. The purpose of the Group is to coordinate efforts among State and local officials and managed care providers to expand managed care to the Medicaid population. The Group currently is meeting the equivalent of two full days per month and expects to meet pursuant to that schedule throughout 1993.

HMOs AND MEDICAID MANAGED CARE

6. Unlike other insurers, HMOs serve Medicaid recipients. Under the State's Medicaid Managed Care Program, HMOs enroll Medicaid recipients into their managed care networks and receive a fixed monthly rate for each individual. Each HMO bears the full risk for the cost of providing care to the Medicaid member. This is in contrast to the usual Medicaid fee-for-service

arrangement in which the Medicaid provider receives a fee for each visit or service. HMOs also insure that Medicaid recipients and their families have a primary physician who monitors their care on a regular basis. This and the availability of a health care network helps reduce costly emergency room visits and unnecessary hospital stays. HMOs currently serve more than 109,000 Medicaid recipients.

7. In April, 1992 the State enacted the 9% surcharge on HMO inpatient care (Chapter 55 of the Laws of 1992). The 9% surcharge is not an increase in the rates that HMOs pay hospitals. Rather, it is a separate charge that is based on the aggregate montly cost of the inpatient hospitalization paid by an HMO. It is paid directly to a statewide pool and thereafter deposited into the State's General Fund. In the case of HMOs that have negotiated alternative hospital rates, the 9% is assessed over and above the negotiated rate.

8. Under the existing statute, an HMO can reduce or eliminate the 9% surcharge for a given year if it (1) has Medicaid contracts with every county in which it operates (subject to certain "good faith" waivers) and (2) enrolls a defined target number of Medicaid recipients. The enrollment target for 1993 and each year thereafter increases until it reaches the State goal of 50% of the non-exempt Medicaid population. According to the State Department of Social Services this is approximately 1.1 million Medicaid recipients.

9. The process for obtaining a county Medicaid contract is lenghtly (approximately nine months) and additional time is necessary thereafter to enroll Medicaid recipients.

10. If an HMO were to stop enrolling Medicaid recipients and the State did prevail on appeal, realistically it would be impossible for the HMO to reenter the marketplace and satisfy the

enhanced target enrollment necessary for exclusion from the 9% surcharge.

11. In 1991 the Legislature enacted the New York State Managed Care Plan (Chapter 165), §364-j of the Social Services Law. This law requires the State Department of Social Services to designate up to twenty local districts annually which will be required to develop and submit managed care plans for approval by the Department, until all non-exempt districts in the State have been designated. In addition, the law sets an enrollment goal of 50% of each district's Medicaid population who are not exempt from participating in the managed care program within five years of managed care plan approval. In effect, this legislation compels counties, for the first time, to develop a managed care strategy and to turn to HMOs and other managed care providers to implement that strategy. The legislation was welcomed by HMOs because it removed serious impediments for HMOs that wanted to enroll Medicaid recipients but encountered apathy or refusal to contract on the part of the counties.

12. In the year following the enactment of Section 364-j of the Social Services Law, Medicaid enrollment in HMOs increased by 52%. This is particularly noteworthy since not all counties were compelled to participate in the first year of the program.

13. The Conference has long recognized its obligation to extend the benefits of Manged Care to Medicaid recipients and is institutionally committed to helping the State achieve its Medicaid enrollment targets pursuant to the State Managed Care Plan.

14. Each member plan of the HMO Conference has established an administrative apparatus and marketing strategy for contracting with counties and enrolling Medicaid recipients. In most cases this has involved hiring new staff and in all cases has involved substantial investment of resources that plans will need to recoup through continued expansion of Medicaid enrollment.

15. Currently, 24 of the 27 plans enrolled in the Conference, including ten of the eleven individually named HMOs, have Medicaid contracts and are enrolling Medicaid recipients. The remainder are involved in negotiations with counties to establish contracts and are prepared to enroll Medicaid recipients as soon as the contracts are in place.

16. Because of the requirements of the New York State Managed Care Plan and the enhanced targets for 1993 and beyond, members of the Conference will continue to aggressively participate in the Medicaid program even if a stay is not granted.

17. The Conference remains committed to help the State achieve its target enrollment goals pursuant to the State Managed Care Plan.

18. Accordingly, the motion of the defendants and intervenor Blues for a stay of the injunction against enforcing the 9% surcharge should be denied.

KATHRYN ALLEN

[Jurat omitted in printing.]

(8) (9) (9)

Nos. 93-1408, 93-1414, 93-1415

Supreme Court, U.S.
FILED
NOV 16 1994
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF FOR PETITIONERS MARIO M. CUOMO, ET AL.

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts a state law which sets hospital rates for all patients, without regard to whether a patient is an ERISA plan participant, but which may have the effect of raising the cost of providing hospital care to some ERISA plans?

2. Whether ERISA preempts a state assessment on health maintenance organizations ("HMOs") which may result in increased cost to ERISA plans that purchase HMO services?

PARTIES TO THE PROCEEDING BELOW

In addition to the petitioners listed in the caption, the following parties are petitioners in this Court: Mark Chassin, M.D., in his official capacity as Commissioner of Health of the State of New York; Salvatore R. Curiale, in his official capacity as Superintendent of Insurance of the State of New York; Michael J. Dowling, in his official capacity as Commissioner of Social Services of the State of New York; and G. Oliver Koppell, in his official capacity as Attorney General of the State of New York.*

In addition to the respondents listed in the caption, the following parties are respondents in this Court: The Health Insurance Association of America; the American Council of Life Insurance; the Life Insurance Council of New York, Inc.; Aetna Life Insurance Company; Aetna Health Plans of New York, Inc.; Mutual of Omaha Insurance Company; Union Labor Life Insurance Company; Professional Insurance Agents of New York, Inc. Trust; New York State Health Maintenance Organization Conference; Health Services Medical Corporation; MVP Health Plan; Wellcare of New York; Mid-Hudson Health Plan; Oxford Health Plan; Capital District Physicians Health Plan; Choicecare Long Island; Independent Health; Travelers of New York; Physicians Health Services; Preferred Care and U.S. Healthcare.

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* Michael J. Dowling succeeded Mary Jo Bane as Commissioner of Social Services on June 30, 1993. G. Oliver Koppell succeeded Robert Abrams as Attorney General of the State of New York on December 30, 1993. Both are automatically substituted pursuant to Fed. R. App. P. Rule 25(d).

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BRIEF FOR PETITIONERS MARIO CUOMO, ET AL.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 14 F.3d 708 and reproduced at JA 30-65.[1] The memorandum opinion of the United States District Court for the Southern District of New York is reported at 813 F. Supp. 996 and reproduced at A-63 to A-90.

JURISDICTION

The Court has jurisdiction pursuant to 28 U.S.C. § 1254(1). The judgment of the court of appeals was entered on October 25, 1993. Subsequently, the court of appeals granted a timely petition for rehearing and issued an amended opinion which was entered on January 14, 1994 (JA30-65). A petition for writ of certiorari was filed on March 10, 1994.

STATUTES INVOLVED

The federal statute involved is the Employee Retirement Income Security Act of 1974 ("ERISA"), § 514(a),(b)(2)(A), 29 U.S.C. § 1144(a),(b)(2)(A). The subsections are reproduced at A-99. The New York statute involved is the New York Public Health Law § 2807-c (McKinney 1993). The relevant subsections are reproduced at A-101 to A-113.

STATEMENT OF THE CASE

This case raises issues about the extent to which ERISA preempts the authority of the states to regulate in the health care field, an area of critical state concern. The Second Circuit Court

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[1] References to the joint appendix filed with this brief are cited as (JA ___). References to the joint appendix filed with the petition for a writ of certiorari are cited as (A-).

of Appeals held that three different, but related, New York State laws, which set hospital rates and impose an assessment on those HMOs which do not enroll a sufficient number of Medicaid recipients, are preempted because they may increase the cost to some ERISA plans of providing health care benefits.

New York contends that ERISA does not preclude it from regulating in the health care field in a manner which treats ERISA plan participants like any other consumer of health care even though as a result of the state laws, some, or even all, ERISA plans may pay more than they otherwise would for the medical goods or services that they purchase. Any other result would confer upon ERISA plans a charmed existence which would exempt them from generally applicable state laws solely because the laws may increase the cost of providing benefits.

A. History of Hospital Rate Regulation In New York State

Prior to the 1960s, New York did not regulate hospital rates. It was common practice for hospitals to negotiate rates with Blue Cross plans that were less than their published charges (JA 161-2). This was known as the "charge differential." The differential reflected the value to the hospitals of prompt and guaranteed payment by Blue Cross plans and recognized the community purpose served by them (JA 162).

By the late 1970s, federal and state cost control laws regulated the rates which hospitals billed patients covered by Medicare, Medicaid, Blue Cross plans, and HMOs. To ensure adequate revenue, hospitals billed patients covered by other payors, including commercial insurers, rates which were 25% to 40% higher than those paid by the regulated payors (JA 149).

In 1983, New York enacted a reimbursement system which set hospital rates for all payors. Hospitals had to bill patients covered by Medicaid, Medicare, HMOs and Blue Cross plans a uniform per diem rate (JA 150). They had to bill all other patients, including those covered by commercial insurers and self-insured groups, or "charge payors," at uniform rates that did not exceed

115% of the Blue Cross rate (JA 150). As a result, the hospital bills of patients covered by charge payors, who had paid 25% to 40% more than Medicaid, Blue Cross or HMO patients, decreased by 8% to 18%.

Charge differentials in favor of Blue Cross and HMOs are justified by cost savings to hospitals and positive social policy outcomes (JA 161-2). The principal cost savings accrue from prompt payment which provides working capital to hospitals and saves them money by reducing collection costs. The positive social policy outcomes include insurance coverage practices, most notably open enrollment and community rating, which make health insurance more available.[2] States in which insurers utilize these practices have between 20% to 30% fewer uninsured persons than the national average (JA 202). New York, in particular, has 20.8% fewer uninsured persons than the national average (JA 203). Studies undertaken by New York in 1958, 1965, 1980, and 1984 concluded that Blue Cross (and to a lesser extent HMOs) were the exclusive, or dominant, payors with these practices (JA 161-163). Blue Cross provides interim advance payments to hospitals, a practice even more advantageous to hospitals than prompt payment (JA 162). Blue Cross utilizes open enrollment and community-rates its small group market (JA 164). In 1984, a legislative report found that Blue Cross had been, and was, the only payor to offer individual and small group policies, without underwriting, at community-rated premiu[illegible]nd that it did so for over five million people in New York State (Exhibit "B" to Anderman Affidavit). In addition, the report noted that Blue Cross provided Medicare supplemental insurance at community-rated premiums to over one million New Yorkers. HMOs provided open enrollment to small groups of five or more and community rate their subscribers. N.Y. Comp. Codes R. & Regs.

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[2] Open enrollment is the practice of offering coverage to any person without regard to prior illness, physical condition, age or sex. Community rating is a methodology in which the premium for all persons covered by a policy form is the same based upon the experience of an entire pool of risks covered by that policy form without regard to age, sex, health status or occupation (JA 200).

tit. 10 § 98.5(b)(19). It was on this basis that a payor differential in favor of Blue Cross and HMOs was originally enacted in 1983 and has been continued to date.[3]

B. Hospital Rate Regulation In New York State From 1988-Present

In 1988, New York enacted the hospital rate-setting system, parts of which are challenged here. It is a prospective reimbursement system based, in large part, on a case payment methodology in which hospitals are paid a set amount for each patient treated, depending on the diagnostic related group ("DRG") to which the patient is assigned. There are 794 DRGs and the rate for each is the average cost of treating a patient in that DRG at a particular hospital (JA 152).[4]

Another component of the hospital rate is a payor differential. Hospitals bill patients who are covered by Medicaid, Blue Cross and HMOs at the case payment rate for the DRG to which the patient is assigned. N.Y. Pub. Health Law § 2807-c(1)(a). Hospitals bill patients covered by workers' compensation, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, "no fault" motor vehicle insurance, commercial insurance, and self-insured funds that make payments

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[3] In addition to Blue Cross and HMOs, New York's Medicaid program receives the benefit of not paying the differential since it provides care to poor New Yorkers, regardless of health condition, who otherwise would be uninsured.

[4] A hospital's DRG rate is the sum of at least six different components, including an operating cost component, a capital cost component, a bad debt and charity care allowance, a trend factor for inflation, and factors reflecting medical malpractice costs and excess medical malpractice costs (JA 152). Some hospitals' DRG rates also include a financially distressed hospital adjustment. The rates for the same DRG vary from hospital to hospital since much of the cost data used to compute a hospital's DRG rates is derived from that hospital's unique cost history and capital costs (JA 152).

directly to hospitals, 113% of the applicable DRG rate, with a 2% discount allowed for prompt payment. N.Y. Pub. Health Law § 2807-c(1)(b),(11)(e). Uninsured patients and patients covered by self-insured funds that do not make direct payments to hospitals are in a third category. They are billed "charges", *i.e.*, prices set by the hospital for the particular services rendered. Charges may not exceed approximately 131% of the DRG rate which would otherwise apply (JA 154).

In 1988, the New York State Department of Insurance reported that Blue Cross plans were losing better risk customers to commercial insurers (JA 164). The commercial insurers, through underwriting practices, insured only the healthiest customers, thereby keeping their rates down and leaving Blue Cross plans with the poorest risks (JA 165-66). After 1988, the Blue Cross plans continued to face shrinkage of their community-rated pools and underwriting losses, which in turn resulted in repeated Blue Cross requests to the Department of Insurance for substantial rate increases (JA 166).

Proposals that address this situation directly were enacted in 1992, and became effective on April 1, 1993. 1992 N.Y. Laws, ch. 501. These provisions, not challenged here, require community rating and open enrollment by all insurers who choose to compete in the individual and small group market.

In addition, in 1992, New York imposed, for a one-year period, an 11% surcharge on the hospital bills of patients covered by commercial insurance. N.Y. Pub. Health Law § 2807-c(11)(i). The 11% surcharge was enacted primarily to remedy the deterioration in the Blue Cross plans' financial position and the effect of that deterioration on New York's health care system (JA 165-66). The 11% surcharge was to be assessed upon hospital bills paid by commercial insurers until the effective date of the new law (JA 167).[5] Hospitals collected the money which was

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[5] The challenge to the 11% surcharge is not moot because respondents refused to pay it. The monies have been paid into escrow (A-94).

then paid over to the State's general fund. N.Y. Pub. Health Law § 2807-c(14-e).

C. The HMO Assessment

New York is among the states attempting to contain escalating Medicaid costs by encouraging Medicaid recipients to enroll in "managed care" programs.[6] In 1992, New York enacted a contingent assessment to be imposed upon HMOs to encourage HMOs to enter into "managed care contracts" with local social services districts and to enroll a target number of Medicaid recipients (JA 175-76). N.Y. Pub. Health Law § 2807-c(2-a). The amount of the assessment is a maximum of 9% of the total inpatient costs of non-Medicaid patients who are enrolled in HMOs. It is eliminated if an HMO becomes a Medicaid managed care provider and enrolls at least 90% of a target number of Medicaid-eligible persons. The 9% assessment is also reduced by 25%, 50% or 75%, if the HMO enrolls a like percentage of a target number of Medicaid-eligible persons (JA 175-76). It is payable on a monthly basis into a statewide HMO pool and credited to the State's general fund (JA 175).

D. The Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, subjects employee benefit plans, including employee pension benefit plans and employee welfare benefit plans, to federal regulation. ERISA was enacted to guard against abuse in the "establishment, operation and administration of

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[6] Managed care is a system of delivering medical care in which a primary care provider is responsible for the management of the medical and health care needs of participants, including referral, coordination, monitoring and follow-up (JA 174). Coordination is particularly significant in Medicaid where there has been a history of uninsured persons' utilizing emergency rooms for primary care. It is intended to save money by emphasizing less costly primary care and by allowing the managed care provider to restrict the use of some expensive medical procedures.

plans." 29 U.S.C. § 1001(a). ERISA requires employee welfare benefit plans to comply with federal standards governing reporting, disclosure and fiduciary responsibilities, 29 U.S.C. §§ 1021-1030, 1101-1114, but it does not prescribe, or otherwise regulate, substantive benefit plan terms.

ERISA expressly provides that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a) (A-99). The preemption provision is substantively qualified by an insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), which states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities" (A-99).

E. Prior Proceedings

On June 2, 1992, the Travelers Insurance Company commenced this action challenging the 13% differential and the 11% surcharge contained in N.Y. Pub. Health Law § 2807-c as preempted by ERISA (JA 1, 68). On August 10, 1992, the Health Insurance Association of America ("commercial insurers") and several insurance companies and trade associations commenced a separate action challenging the 9% HMO assessment, in addition to the 13% differential and 11% surcharge, as preempted by ERISA (JA 16).[7] The actions were heard together and the parties cross-moved for summary judgment on all claims (JA 2, 3, 4).

On February 3, 1993, the district court issued a decision and order holding that the 13% differential, the 11% surcharge, and the 9% HMO assessment (the "health care assessments") were preempted by ERISA because they "lead, indirectly, to an increase in plan costs" (A-71). While recognizing that none of the state

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[7] The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York State intervened as defendants (JA 2). The New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs (JA 4).

laws has a direct effect on the structure or administration of ERISA plans, the court nevertheless held that indirect economic impact may affect the structure and administration of plans by encouraging plans to reduce the level of benefits, a result "which ERISA was designed to avoid" (A-74). The district court acknowledged that its decision meant that states would be precluded from regulating hospital rates for patients who are covered by ERISA plans, but said that any concern about this consequence had to be directed to Congress, not the courts (A-78). The district court also held that none of the challenged provisions were within ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), which exempts from preemption laws regulating insurance (A-80). The district court enjoined enforcement of the assessments against commercial insurers and HMOs (A-90).

On October 25, 1993, the United States Court of Appeals for the Second Circuit affirmed the district court's holding that the health care assessments relate to ERISA plans because they impose a significant economic burden on commercial insurers and HMOs, and thereby have an impermissible impact on the structure and administration of ERISA plans (A-24).

The Second Circuit found that the 13% differential and the 11% surcharge were designed to increase hospital costs for patients covered by health plans other than Blue Cross and, therefore, "obviously" affected ERISA plans' health care benefits (JA 52). Likewise, the court held that the 9% assessment increased the cost of HMO coverage, thus interfering with an ERISA plan's selection of the most effective way to provide benefits (JA 52). This interference was held sufficient to constitute a connection with ERISA plans (JA 52).

The Second Circuit also held that the health care assessments related to ERISA plans because they substantially increased the cost to ERISA plans of providing a given level of health care benefits. The court expressly rejected the argument that indirect economic impact, standing alone, does not support a finding of preemption (JA 54). It also expressly declined to follow the reasoning of the Third Circuit in *United Wire, Metal & Mach.*

Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, (3rd Cir.), *cert. denied*, 114 S.Ct. 382 (1993), holding that a similar New Jersey hospital rate statute's "indirect ultimate effect of increasing plan costs" placed it beyond ERISA preemption (JA 55).

The Second Circuit also rejected the argument that the assessments were saved from ERISA preemption because they regulated insurance. The court held that the 13% differential and the 11% surcharge did not come within the common-sense meaning of the term "regulates insurance" because they regulate hospital rates (JA 57). Applying the three insurance factors from the McCarran-Ferguson Act, 15 U.S.C.§ 1011 *et seq.*, the court held the state laws met only one; they affected the transfer or spreading of a policyholder's risk by encouraging plans to switch to Blue Cross (JA 59). The Second Circuit held that they did not regulate any practice that is integral to the insurer-insured relationship and were not limited to entities within the insurance industry and, therefore, were not saved from ERISA preemption (JA 59-60). Finally, the court held that HMOs were not, as a matter of law, in the business of insurance so that the 9% assessment was also not saved by the insurance saving clause (JA 60). The court granted New York's petition for rehearing and issued an amended opinion on January 14, 1994. It addressed an issue not decided in the original opinion, but did not alter its ERISA preemption analysis.

SUMMARY OF ARGUMENT

The health care assessments are state laws of general application which affect the cost of hospital services, but which do not, directly or indirectly, dictate or restrict ERISA plans' benefits, structure, or administration. They, therefore, do not "relate to" plans. The assessments are part of the State's hospital rate regulation system which affect employee benefit plans only to the extent that plan participants purchase inpatient hospital care in the health care marketplace. The 13% differential and the 11% surcharge are imposed on hospital bills paid by third-parties on behalf of hospital patients without regard to the payor's

relationship to ERISA plans. Hospital patients who are ERISA plan participants fall within all payor categories, and all payor categories include both ERISA plan participants and others. The 9% assessment is imposed upon HMOs, without regard to whether their customers are ERISA plan participants.

While ERISA plans are a major source of private health care coverage, that fact does not transform the health care assessments into laws directed at ERISA plans or dependent on ERISA plans' existence. Thus, these laws do not fit within decisions of the Court that have preempted state laws on that basis. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), and in *District of Columbia v. Greater Washington Board of Trade*, ___ U.S. ___, 113 S. Ct. 580 (1992), the Court preempted statutes which could not be meaningfully applied without reference to ERISA plans. Here, the health care assessments would function in exactly the same way even if ERISA plans did not provide health care coverage as a benefit. ERISA plans' predominance in the health care market also does not alter the analysis of whether a law's impact on plans is remote and tenuous. That analysis depends upon the nature of the impact on ERISA plans, not the number of ERISA plans affected.

The health care assessments may have an indirect economic effect upon ERISA plans. The Court has never addressed whether ERISA preempts a state law that may have solely an economic effect on ERISA plans' cost of providing benefits. Cases in which the Court preempted state laws involved state regulation which dictated or restricted plan conduct. However, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the Court upheld a state garnishment statute that imposed requirements upon plan administration, rejecting the argument that the substantial economic and administrative burdens the statute imposed upon plans required preemption. In construing the meaning of "relate to," the Court looks to the congressional purpose of ERISA preemption, to allow uniform administration of plans. The health care assessments do not raise this concern as they do not dictate or restrict plan administration. While the assessments may affect ERISA plans' cost of doing business, plans remain subject to

nationally uniform supervision. The costs of providing benefits necessarily varies from state to state, with or without the health care assessments.

Economic impact upon plans, even a substantial economic impact, by itself is not a sufficient connection to plans to "relate to" them. States regulate extensively, pursuant to their police power, in the health care field and in other areas where ERISA plans provide benefits. Police power regulation will have a financial impact on plans' cost of providing benefits. The health care assessments, like state regulation of hospital capital improvements, medical waste disposal, minimum hospital staffing requirements, and a whole host of other regulations, increase the cost of providing medical care and, therefore, the cost of health care coverage provided by plans. As the cost of medical care increases, plans may respond by reducing benefits, but there is nothing in ERISA's language, structure, or legislative history to indicate that ERISA was designed to protect participants from this possibility.

The health care assessments may influence plan content or administration because they do not affect all payors equally. State regulation does not affect every aspect of plan administration or benefits identically and, therefore, a wide range of state regulation may influence ERISA plan activity. However, this effect does not "relate to" plans because it does not dictate or restrict plan content or administration.

Even assuming the Court decides that the health care assessments "relate to" ERISA plans, the 13% differential and the 11% surcharge are saved from preemption as laws regulating insurance. The 13% differential and the 11% surcharge meet the Court's "common-sense" test because they are specifically directed at the insurance industry and seek to ensure its viable functioning by facilitating the transfer and spreading of risk. The 11% surcharge was imposed only upon commercial insurers and was designed to remedy the problem of poorly distributed risk by stemming the continued shrinkage of the Blue Cross plans' community-rated risk pools. The 13% differential is, in effect, a

discount from the basic rate, DRG plus 13%, for those payors which use the risk-spreading practices of open enrollment and community rating. It is imposed to account for the greater costs incurred by Blue Cross plans and HMOs as a result of these risk-spreading practices. Although HMOs are hybrid entities, the 13% differential affects them only in their insurer function which HMOs perform when they practice open enrollment and community rating.

The 13% differential and the 11% surcharge also meet all of the three factors enunciated by the Court in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), to determine what constitutes the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* The 13% differential and the 11% surcharge meet the first *Pireno* factor as they spread risk by compensating insurers with the broadest risk pools for the higher costs of insuring the poorest risks who, but for these practices, might not be insured. They meet the second *Pireno* factor by fostering, through open-enrollment and community rating, the formation of policy relationships without regard to age, sex, health or occupational status. Finally, they are limited to entities in the insurance industry since they are imposed only by virtue of a payor's status in the insurance marketplace.

Furthermore, the Court has interpreted the *Pireno* factors more broadly when evaluating state laws for preemption purposes under the McCarran-Ferguson Act than when evaluating them for anti-trust purposes. *United States Department of Treasury v. Fabe*, ___ U.S. ___, 113 S. Ct. 2202 (1993). ERISA's insurance saving clause serves the same policy as the preemption-limiting clause of the McCarran-Ferguson Act and, therefore, the broader reading of the business of insurance should apply in this case.

ARGUMENT

POINT I

THE HEALTH CARE ASSESSMENTS DO NOT RELATE TO ERISA PLANS SINCE THEIR ONLY CONNECTION TO PLANS MAY BE TO INCREASE INDIRECTLY SOME ERISA PLANS' COST OF PROVIDING HEALTH COVERAGE.

ERISA preempts state laws that "relate to" ERISA plans. The words "relate to" are broad, but not unlimited. They are to be given their common-sense meaning of having "a connection with or reference to" a plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983). The health care assessments have none of the connections to plans which the Court in prior decisions has held to "relate to" plans. The assessments, like many other state regulations, may affect a plan's cost of doing business. However, this effect is not one which ERISA preemption was designed to prevent. While differences in the cost of benefits may influence a plan's decisions concerning its scope and content, such an effect does not restrict or dictate benefit choices or plan administration. It does not, therefore, result in ERISA preemption.

A. The Health Care Assessments Are Laws of General Applicability Which Neither Single Out ERISA Plans for Special Treatment Nor Are Predicated upon the Existence of Plans.

New York's health care assessments are state laws of general application with only a "tenuous, remote or peripheral connection" to employee benefit plans and, as such, do not relate to plans. *District of Columbia v. Greater Washington Board of Trade*, ___ U.S. ___, 113 S. Ct. 580, 583, n. 1 (1992). The health care assessments do not single out ERISA plans or subject them to

special treatment.[8] Hospitals are required to bill all patients, including participants in ERISA plans, according to the statutory methodology. ERISA plan participants fall within all three payor categories depending on the type of health care coverage provided by the plan. Those who have HMO or Blue Cross coverage are charged the DRG rate. N.Y. Pub. Health Law § 2807-c(1)(a). Those who have commercial insurance or whose plans self-insure and make payments directly to the hospital are charged 113% of the DRG rate. N.Y. Pub. Health Law § 2807-c(1)(b). Other ERISA plan participants are billed charges which cannot exceed approximately 131% of the DRG rate. N.Y. Pub. Health Law § 2807-c(1)(c). Many ERISA plans give participants a choice of health care coverage, for example, HMOs or commercial insurance. These plans have participants in more than one payor category. Moreover, all three payor rate categories apply to both ERISA and non-ERISA covered patients.[9]

The health care assessments affect employee benefit plans only to the extent that plan participants are consumers in the health care market. The 13% differential and 11% surcharge, imposed upon hospitals bills covered by certain third party payors, apply irrespective of the relationship between those payors and ERISA plan participants. The 9% assessment is imposed directly upon HMOs, again irrespective of any relationship between an HMO and an ERISA plan participant. The commercial insurers and HMOs have argued that laws directed at health care are not generally applicable and their impact upon ERISA plans is not "remote and tenuous" because most Americans who have private health care coverage receive it through employee benefit plans. The Second Circuit agreed, stating in the first line of its opinion: "Eighty-eight percent of all non-elderly Americans have private

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[8] We use the short-hand term "ERISA plans" instead of employee benefit plans, while recognizing that some employee benefit plans are exempt from ERISA coverage and, thus, are not implicated in this case, *e.g.*, governmental plans. 29 U.S.C. § 1003(b)(1).

[9] For example, Blue Cross, HMOs, commercial insurers, and self-insured funds cover ERISA and non-ERISA plan participants and others.

health care insurance through their employee welfare benefit plans" (JA 35).[10] The court's analysis, grounded on the fact that ERISA plans are a major source of private hospital care coverage, incorrectly transforms the health care assessments from laws of general applicability into ones directed at ERISA plans.[11] A law

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[10] The Second Circuit reiterated this view in its subsequent opinion in *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823 (1994). In *NYSA-ILA*, the Second Circuit held that a 0.6% assessment on hospital gross receipts, including receipts for patient care services, was preempted insofar as it was applied to a medical facility owned by an ERISA plan. Rejecting New York's argument that the assessment was a state tax law of general applicability which affects ERISA plans only incidentally, the court held:

> The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in, such as purchasing gasoline or paying one's employees. Rather, the HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them.

Id. at 827.

[11] The primary purpose of these assessments is to control health care costs and to reduce the number of uninsured New Yorkers by assuring widely available and affordable coverage, especially in the small group market (JA 163). A recent government report found that 75% of the Americans who lack health insurance are workers (and their dependents) and over half of these workers are employed in firms of 25 or fewer, *i.e.*, employers in the small group market. In addition, the report noted that 30% of small businesses are considering dropping health care benefits because of the cost. General Accounting Office, ACCESS TO HEALTH INSURANCE: STATE EFFORTS TO ASSIST SMALL BUSINESSES, GAO/HRD-92-90 (May 1992). Yet, these facts do not transform the health care assessments into laws designed to interfere with an ERISA plan's decisions whether or not to provide health care benefits.

of "general applicability" is one applicable to a broader class than that at issue in a particular case.[12] As applied to ERISA cases, a law of general applicability is one not restricted to employee benefit plans and which does not accord them any different treatment. The fact that employee benefit plans are a large segment of a broader class covered by a law does not make the law any less one of general applicability. Nor does it transform state laws which regulate generally in the health care field into laws which single out ERISA plans.

Statistics do not alter the analysis of whether a state law's impact on plans is "remote and tenuous." Whether a law's relationship to an ERISA plan is remote and tenuous must depend on the nature of the impact on the plan, not on how many plans are affected. ERISA plans are the primary source of private health care coverage. Thus, unless plans are specifically excluded from state health care regulation, much of the impact of regulation in the health care field will obviously fall on them.[13] In this case, the argument that the health care assessments "relate to" plans because they are paid primarily by plans tells only part of the story since the benefit of avoiding the 13% and 11% provisions also

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[12] *Gade v. National Solid Wastes Management Ass'n.*, ___ U.S. ___, 112 S. Ct. 2374 (1992), involved preemption under the Occupational Safety and Health Act, 29 U.S.C. § 651 *et seq.* The Court noted that, in that context, non-occupational safety laws which affected workers, such as traffic safety laws or fire safety laws were laws of general applicability. 112 U.S. at 2387-8. In *New York State v. United States*, ___ U.S. ___, 112 S. Ct. 2408 (1992), a Tenth Amendment case, the Court indicated that laws that subjected states to the same standards as private parties were "generally applicable laws." 112 S.Ct. at 2420.

[13] *See, e.g., New England Health Care Employees Union Dist. 1199 v. Mt. Sinai Hospital*, 846 F.Supp. 190, 196 (D.Conn. 1994) in which the court, relying on the Second Circuit's decision in *Travelers*, held that a generally applicable assessment on hospital revenue, which was passed through to ERISA plans that paid their participants' bills, was preempted because 70% of the money raised by the assessment came from ERISA plans.

falls primarily on ERISA plans—those that use Blue Cross or HMOs. This result flows from plans' predominance in the health care market, not from the state laws' effect on those ERISA plans. Under the quantitative analysis of impact used by the Second Circuit, if a large percentage of working Americans obtain child care through ERISA plans, state regulation of day care centers would also be preempted, because it would affect the cost of a benefit provided by a large number of ERISA plans.

The health care assessments are not predicated upon the existence of ERISA plans, as were the state laws at issue in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, or *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580. In *Ingersoll-Rand*, 498 U.S. at 140, the Court held that a state law cause of action for wrongful termination, when the employer's motivation was to avoid paying pension benefits, "related to" plans because, without a pension plan, there would be no cause of action. In *Greater Washington Board of Trade*, 113 S. Ct. at 583, the Court held that a law, which imposed requirements only on employers who provided health care benefits and which tied the requirements to the level of benefits provided by the employer's benefit plan, "related to" plans because it referred to and was dependent upon the existence of plans. As the Third Circuit recognized in *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d at 1192, n. 4, in those cases the statutes could not be meaningfully applied but for the existence of ERISA plans. In contrast, hospital rate-setting statutes, and the particular components challenged in this case, can be applied and would function even if ERISA plans did not provide health care coverage as a benefit.[14] The same is true of the HMO assessment, which is predicated upon the existence of HMOs, not upon the identity of their non-Medicaid customers.

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[14] If non-indigent patients do not obtain hospital care coverage as an employment-related benefit, they must either obtain their own health insurance coverage, at which point they will fall under N.Y. Pub. Health Law § 2807-c(1)(a) or (b) or (c), depending on which coverage they have, or they will be uninsured and treated as "charge payors" under N.Y. Pub. Health Law § 2807-c(1)(c).

There is no evidence that Congress, in enacting ERISA, envisioned that ERISA plans would displace the states' ability to regulate in areas of traditional state concern simply by providing benefits in the area. The benefits that ERISA plans provide, health care, child care, legal services, disability and life insurance, are areas of traditional state concern. There is little or no federal substantive regulation in these areas. Congress did not intend "fundamentally to alter traditional preemption analysis," when it designed ERISA, *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, ____ U.S. ___, 114 S. Ct. 517, 526 (1993). Therefore, it must be "presume[d] that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985), quoting *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977).

There is nothing in ERISA's language, structure or legislative history which demonstrates a congressional intent to preempt generally applicable state health care regulation merely because ERISA plans provide a substantial portion of health care coverage. ERISA does not require employers to provide health care coverage or any other employee benefit. ERISA was intended to "preempt the field for Federal regulation, thus, eliminating the threat of conflicting and inconsistent State and local regulation of employee benefit plans." 120 Cong. Rec. 29933 (1974) (statement of Senator Williams). That is a different and more limited purpose than creating a regulatory vacuum in an area of traditional state concern simply because employee benefit plans provide benefits in that area.

B. The Indirect Economic Impact of State Regulation upon Plans is Not Sufficient to Trigger Preemption Because it Does Not Dictate or Restrict Plan Benefits, Structure or Administration.

The impact of the health care assessments on ERISA plans is an indirect economic one. The effect is indirect because the assessments are not imposed upon ERISA plans, but rather upon services which plans may purchase on behalf of their participants.

The 13% differential and the 11% surcharge are components of a state law which requires hospitals to bill patients for services at certain rates. Although the calculation of a patient's hospital bill takes into account the identity of the payor involved, the law does not require any ERISA plan or third party payor to pay any benefit, any level of benefit, or any particular amount of a patient's hospital bill. Similarly, the 9% assessment requires HMOs to pay a variable assessment, but does not hold any ERISA plan responsible for the payment.

The impact of the assessments upon plans is, thus, solely economic, inasmuch as the assessments affect only the price of services which ERISA plans may purchase. Depending on whether an ERISA plan is insured or self-insured, the 13% differential and the 11% surcharge may affect either the price of insurance or the price of hospital care paid on behalf of a participant. The 9% assessment may affect the price of HMO services purchased by a plan.

1. Prior Decisions of the Court Suggest that a State Law's Indirect Economic Impact Alone Does Not Trigger ERISA Preemption.

The Court has never held that ERISA preempts a state law with solely an indirect economic impact on plans. State laws which refer to, are predicated upon, or which function only through the existence of, ERISA plans are preempted. Thus, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, a state law cause of action that would not exist but for the existence of a pension plan was held to "relate to" plans.[15]

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[15] In *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580, a state law was preempted for similar reasons. The state law referred to and imposed requirements by reference to employee benefit plans. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, that portion of a state law that made specific reference to "ERISA plans" and singled them out for different treatment was preempted. As

(continued...)

All of the Court's prior ERISA preemption cases involved state laws which affected ERISA plans by regulating, directly or indirectly, substantive plan conduct or plan administration. Thus, state laws have been found to "relate to" plans when they conflict with substantive provisions of ERISA, as in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). In that case, a New Jersey statute that prohibited plans from decreasing pension benefits by the amount of workers' compensation benefits awarded after retirement was held to "relate to" plans. Although the law affected plans indirectly through a workers' compensation statute, it prohibited plans from using a method to calculate benefits that was permitted by ERISA. Laws have been found to "relate to" plans when they directly or indirectly imposed substantive requirements upon plan conduct. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, a Massachusetts insurance law that mandated minimum benefits for plans that purchased insurance "related to" plans. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97, that portion of New York's Human Rights Law which, by prohibiting sex discrimination in employment, would have required plans to provide pregnancy disability benefits was held to "relate to" plans. State laws that require plans to be structured in a particular manner "relate to" plans. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), a Pennsylvania anti-subrogation statute, which prevented plans from being structured so as to require reimbursement from a third party in the event of recovery, "related to" plans. Finally, laws that provide an alternative cause of action for collecting benefits, such as the state cause of action for improper processing of a claim, "relate to" plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41.

However, prior decisions of the Court have suggested that economic impact is insufficient to result in ERISA preemption. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, the Court upheld a Georgia garnishment statute that directly imposed substantive requirements upon plans. As garnishees, plan

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[15](...continued)
the Second Circuit recognized, the health care assessments do not refer to ERISA plans and, therefore, this line of cases is inapplicable.

trustees had to become parties to state lawsuits and make decisions with respect to the validity and priority of garnishments. They were even subject to state substantive law concerning spendthrift trusts. Yet, the Court rejected the argument that these substantial economic and administrative burdens alone required preemption. Moreover, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 741, the Court, in dicta, noted that laws which regulate only an insurer or how it sells insurance do not "relate to" plans. Yet, those laws increase the cost of insurance over what it would be in the absence of regulation and may increase the cost of ERISA plans that purchase insurance.[16]

2. State Laws that Affect the Prices that Plans Pay for Goods and Services Do Not Interfere with Plan Uniformity.

The Court has always been careful to construe the meaning of "relate to" in the context of the congressional purpose of ERISA preemption. Indirect economic impact alone does not implicate the congressional concerns of ERISA preemption, at least not when the impact is the result of higher benefit prices. The purpose of ERISA's preemption provision is to eliminate conflicting and inconsistent regulation of benefit plans. 120 Cong. Rec. 29197 (1974). Congress believed that uniform regulation would "help administrators, fiduciaries, and participants to predict the legality

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[16] In New York, commercial insurers, HMOs and Blue Cross are subject to examinations by the state, N.Y. Ins. Law § 309 (commercial insurers)' N.Y. Pub. Health Law § 4409 (HMOs), N.Y. Ins. Law § 4313(a) (Blue Cross); are required to prepare detailed annual financial reports, N.Y. Ins. Law § 307(a) (commercial insurers), N.Y. Pub. Health Law § 4408 (HMOs), N.Y. Ins. Law § 4313 (Blue Cross); are required to be audited by outside certified public accounting firms, N.Y. Ins. Law § 307(a) (commercial insurers), N.Y. Pub. Health Law § 4408 (HMOs), N.Y. Ins. Law § 4313 (Blue Cross); and have their loss reserves certified by a qualified actuary, N.Y. Ins. Law § 1303 (commercial insurers), N.Y. Pub. Health Law § 4408 (HMOs), N.Y. Ins. Law § 4310 (Blue Cross). Reserves, both minimum amounts and minimum length of time held, are also regulated. *Id.* All of these requirements increase operating costs.

of proposed action without the necessity of reference to varying laws." House Rep. No. 533, 93rd Cong., 1st Sess. 12 (1973). Thus, plans would only have to look to federal law to determine if their conduct is legal. Uniformity would be achieved by conforming conduct to one set of federal requirements. If there were no federal requirements (as is often the case with welfare benefit plans), plans would be free to develop their own requirements. In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court described the problems created for plans by conflicting or inconsistent state and local regulations as follows:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations. . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States.

482 U.S. at 9.

New York's health care assessments do not raise these concerns. They do not require plans to provide additional or different benefits, to calculate eligibility for benefits, or to process claims any differently. They do not interfere with record-keeping requirements or vary fiduciary standards. Increases in hospital bills or insurance premiums do not interfere with, or modify, plan terms. Regardless of the amount of the hospital bill, the plan's responsibility is governed by its plan terms, whatever they are.

The fact that the health care assessments may make hospital bills or insurance premiums more expensive than they would otherwise be or than they may be in other states does not cause increased administrative burdens to plans. Plan administrators do not have to do anything different in New York because a participant's hospital bill is higher. It takes no more

administrative effort to process a claim for $113 than to process one for $100.

State laws that affect only the price of goods or services which plans purchase do not interfere with interstate uniformity. Preemption of state laws that impose, directly or indirectly, substantive obligations on plans, results in uniform obligations. Preemption of state laws that affect only the cost of benefits, however, does not result in uniform costs. Even in the absence of state hospital rate regulation, plans would not pay the same amount for hospital care in each state. Plans can be, and indeed are, subject to nationally uniform supervision although their costs of doing business vary from state to state, or even from city to city.

3. A State Law Does Not Relate to Plans Because of the Degree of Its Economic Impact on Plans.

The Second Circuit, relying principally upon the Court's decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, held that the health care assessments "relate to" plans because the plans might respond to the "substantial economic impact" of the assessments on the cost of benefits by reducing benefits (JA 52-53).

However, neither *Ingersoll-Rand* nor any other decision of the Court has interpreted the phrase "relate to" in such a broad fashion. In *Ingersoll-Rand*, the Court recognized that ERISA preemption is not limited to state laws that "purport to regulate" ERISA plans, that are specifically designed to affect ERISA plans, or that directly affect ERISA plans. However, the state law at issue in that case, a cause of action for wrongful termination when the employer's motivation was to avoid paying pension benefits, while affecting plans only indirectly, made "specific reference to," and "was premised on the existence of a pension plan." *Ingersoll-Rand*, 498 U.S. at 140. Thus, the Court was careful to note that it was not dealing with a law of general applicability that makes "no reference to and, indeed, functions irrespective of the existence of ERISA plans." 498 U.S. at 139.

In addition, the Second Circuit's use of "substantial" provides no objective limitation to the economic impact standard. It is not the degree of the financial impact which determines if a state law is preempted. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, the Court recognized "[l]awsuits against ERISA plans for run-of-the-mill state law causes of action such as unpaid rent, failure to pay creditors, or even torts committed by ERISA plans are relatively commonplace . . . [and] although obviously affecting and involving ERISA plans are not preempted by ERISA." 486 U.S. at 833. Yet these suits, too, can have substantial negative economic effects upon plans. There are areas in which states regulate, without regard to ERISA, which can result in significant negative economic effects on plans. States regulate electricity, water, sewer, and heating oil rates, often to the significant financial disadvantage of certain groups, which could include ERISA plans. For example, New York requires telephone companies to charge higher commercial rates which subsidize lower residential rates. ERISA plans, which pay commercial rates in New York, pay higher rates than they would if the state did not require this differential.

New York regulates extensively in the health care area and any number of these regulations affect the cost of providing health care coverage. New York regulates hospitals' expansion and other capital improvements and includes a capital cost component in the DRG rate. N.Y. Pub. Health Law § 2802, 2807-c(8). The State regulates the training of doctors and the working conditions of residents and allows training hospitals to include these costs in their rates. N.Y. Pub. Health Law § 2807-c(7)(c), N.Y. Comp. Codes R. & Regs. tit. 10 § 404.4(b). The State imposes staffing requirements and regulates the working conditions of medical support personnel. N.Y. Comp. Codes R. & Regs. tit. 10 part 405. It imposes sanitary standards on hospitals. N.Y. Pub. Health Law §§ 1389-aa--1389-hh. All of these regulations can significantly increase the rates for hospital care and, therefore, the price paid by ERISA plans directly, or indirectly through an insurer. As the Third Circuit recognized in *United Wire Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d, at 1196 states are beginning to regulate the

disposal of medical wastes. Such regulation can significantly increase a hospital's, medical laboratory's or a physician's cost of doing business and, correspondingly, its billings to ERISA plan participants. Some states cap malpractice awards against physicians and an increase in that cap would increase the cost of physicians' malpractice insurance and, thus, the physicians' billings to ERISA plan participants.

State regulations may also affect the cost of other benefits ERISA plans provide. New York regulates the cost of tuition at state universities. N.Y. Educ. Law § 201 *et seq.* It sets minimum standards for day care centers. N.Y. Soc. Serv. Law §390. Increases in the cost of tuition at state universities would force plans which provide tuition assistance to absorb increased costs or reduce benefits. Enactment of more stringent day care regulations would likely increase the costs of operating day care centers, forcing plans who provide child care benefits to absorb the increased cost or reduce benefits. All of these increases in areas where ERISA plans provide benefits may be substantial. Yet there is nothing in the structure, purpose, or the legislative history of ERISA which indicates that Congress intended ERISA plans to be exempt from increases in the price of benefits provided.

Nor is there any evidence that, in enacting ERISA, Congress was concerned with protecting plan participants from increased benefit prices. The statutory structure of ERISA does not protect a plan participant's right to specified welfare benefits. ERISA does not require the provision of benefits. It does not govern the substantive terms of employee welfare benefit plans. ERISA contains no provisions which guarantee minimum welfare benefits, unlike pension benefits. There are no vesting requirements and no minimum funding requirements for welfare plans. The primary congressional purpose in regulating welfare plans was to prevent trustee mismanagement of funds—a purpose which is not implicated in any way by state regulations that increase benefit costs.

Congress allowed employers subject to ERISA the freedom to change or eliminate medical benefits (as opposed to vested pension

benefits) because of the variables that make predicting future medical costs difficult, if not impossible. Plans are often amended to contain costs and these amendments have been uniformly upheld when challenged by plan participants. *McGann v. H & H Music*, 946 F.2d 401 (5th Cir. 1991) *cert. denied*, ___ U.S. ___, 113 S. Ct. 482 (1992); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2nd Cir. 1988); *Musto v. American General Corp.*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

Even if substantial economic impact provided a basis for meaningful analysis, the Second Circuit did not apply it in a useful manner. Looking at the naked percentages, 9, 11, 13, the court of appeals held the economic impact was substantial. However, those numbers alone do not reflect the impact on the plans or its costs.[17] For example, the 9% assessment may be reduced or eliminated by HMOs that enroll their target number of Medicaid recipients. The record shows that HMOs that were assessed the full 9% raised their rates 3.5% (Rachlin Affidavit and Exhibits). Thus, a plan in which 20% of the participants are enrolled in such HMOs would experience only a 0.7% increase in health care costs. The actual impact of the 13% and 11% assessments also varies depending upon whether a plan is insured and the percentage of plan expenditures which are spent on inpatient hospital care. Moreover, the 13% and 11% are components of a comprehensive rate-setting scheme that was designed to control increases in hospital costs. Private payors, such as ERISA plans, have benefitted enormously from this cost control scheme. Even

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[17] After the *Travelers* decision, courts have struggled with meaningful application of this test. In *Boyle v. Anderson*, 849 F. Supp. 1307, 1315 (D. Minn. 1994) the court distinguished *Travelers*, holding that Minnesota's 2% provider tax was not substantial. In *New England Health Care Employees Dist. 1199 v. Mt. Sinai Hospital*, 846 F.Supp. at 196, two 6% assessments on hospital income were deemed substantial. In *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823, the Second Circuit preempted a 0.6% generally applicable hospital assessment which the district court had found to be *de minimis* on the basis that, because an ERISA plan owned the hospital, it was a direct tax on benefits.

with the differentials, private payors pay a lower "surcharge" over cost in New York than in any other state.[18]

C. State Laws Do Not Relate to Plans Simply Because They Influence Plan Choice.

New York's health care assessments do not "relate to" plans because they do not, directly or indirectly, impose obligations upon plan conduct. The assessments also do not dictate or restrict an ERISA plan's choice of benefits, its structure, or its administration. Collectively, they affect only the price of obtaining health care coverage from HMOs, Blue Cross, and commercial insurers and the price of hospital bills paid by self-insured funds. Since the assessments affect these payors differently, costs are not affected uniformly. Plans that take these costs into consideration may be influenced in their choices of the content or structure of their benefit plans. In the Second Circuit's view, the assessments "relate to" plans because they are not equally applicable to all forms of coverage. This was believed to result in interference with "the choices that ERISA plans make for health care coverage" (JA 52).[19] The fact that the health care assessments may affect the costs of the various forms of health care coverage unequally is irrelevant. All kinds of state regulations have an economic impact upon plans which may influence plan content or administration. There is a legally significant distinction between influencing plan choice and mandating plan conduct. State laws that do not mandate plan conduct do not "relate to" plans because they may influence plan

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[18] The federal Prospective Payment Assessment Commission ("ProPAC") reported in the 1993 Report to Congress, *Medicare and the American Health Care System*, that private payors in New York in 1991 paid a lower "surcharge" over costs (23% below the average) than did private payors in any state. ProPAC's June 1994 report showed that New York's private payors in 1992 were still paying the lowest surcharge--25% below the national average.

[19] There is no evidence in the record that any plan changed health care coverage as a result of the health care assessments.

decisions concerning content and administration of plans.[20] Just as an indirect economic impact is not enough to "relate to" plans, neither is the unequal economic impact of the health care assessments enough to "relate to" plans.

The health care assessments are no different than any other state regulation which, in myriad ways, may affect the costs of goods and services which a plan purchases and which, in turn, influence a plan's decisions concerning its content and administration. New York regulates the internal operation of commercial insurers, Blue Cross, and HMOs. These regulations are not identical and affect these insurers' comparative rates which, in turn, may influence plan choice.[21] New York's

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[20] In *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, the Court, in discussing *Shaw v. Delta Air Lines, Inc.* 463 U.S. 85, stated that "the fact that employers could comply with New York law by administering the required disability benefits through a multibenefit ERISA plan did not mean that the law related to such ERISA plans for pre-emption purposes." 113 S.Ct. at 584. However, New York's disability law could well influence decisions regarding the content and scope of ERISA plans. Plan sponsors who wish to avoid the administrative burden of having multiple plans may be influenced to include New York's minimum disability benefits as part of their multi-benefit plan. Multi-state plan administrators have an incentive to adopt the disability benefits required by the state with the most stringent requirements, so the plans can have nationwide uniformity in benefits. Plans may absorb the costs of these additional benefits or they may avoid these increased costs by reducing other benefits.

[21] For example, only HMOs may enter into provider capitation agreements, N.Y. Comp. Codes R. & Reg. tit. 10 § 98.5. This allows only HMOs to spread risk to medical providers and enhances their competitiveness with Blue Cross and commercial insurers. New York imposes different requirements upon Blue Cross, HMOs and commercial insurers regarding permissible investments. Blue Cross and HMOs are allowed only narrow categories of permissible investments and are subject to strict quantitative and qualitative standards. N.Y. Ins. Law § 1404. Commercial insurers are permitted much broader categories of

(continued...)

hospital rate-setting statute allows only HMOs to negotiate discounts from the DRG rate. N.Y. Pub. Health Law § 2807-c(2)(b)(i). HMOs that take advantage of this option have lower hospital costs than any other payor. To the extent this advantage is reflected in their rates, it can influence plan choice.

Moreover, the interference argument cannot be logically limited to insulate only a plan's choice of a health care provider. In New York, for example, inpatient care is regulated much more closely than outpatient care. If this stricter regulation results in a significant increase in the cost of inpatient care, a plan might decide to reduce inpatient benefits and increase outpatient benefits. If New York significantly raises the tuition at its state universities, a plan might choose to reduce tuition assistance and increase day care benefits. A plan's choice of the benefits it offers, or the level of benefits it provides, is certainly as integral to its structure as is its choice of a third party provider of the benefits. If a plan's determination of its menu of benefits can legitimately be influenced indirectly by state regulation that increases the cost of the benefits offered, then so too can the plan's choice of who will distribute the benefits.

POINT II

THE 13% DIFFERENTIAL AND 11% SURCHARGE ARE LAWS REGULATING INSURANCE AND, THEREFORE, ARE SAVED FROM PREEMPTION.

Assuming, *arguendo*, that the Court decides that the 13% and 11% provisions "relate to" ERISA plans, they are not preempted

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[21](...continued)
investments and are subject only to a prudent person rule. N.Y. Ins. Law § 1405. The commercial insurers who are allowed greater discretion in investing have a greater opportunity for higher return and, therefore, more latitude in setting rates.

because they come within ERISA's insurance saving clause.[22] The saving clause states broadly that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).[23] The insurance saving clause must be broadly construed with due regard for the states' traditional powers in the field of insurance. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S., at 741. The 11% differential and the 13% surcharge, although part of the hospital rate-setting methodology, regulate insurance since they are imposed in connection with payor risk-spreading practices. In addition, they seek to ensure the viable functioning of the insurance industry by facilitating the transfer and spreading of risk.

To determine whether a law regulates insurance within the meaning of the saving clause, a court must first take a "common-sense view" of the phrase "regulates insurance." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 50; *Metropolitan Life v. Massachusetts*, 471 U.S. at 740. To be considered a law which regulates insurance, "a law must not just have an impact on the

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[22] New York did not argue that the 13% differential fell within the insurance saving clause in the Second Circuit, but believes that the Court's decision in *United States Department of Treasury v. Fabe*, 113 S.Ct. 2202, decided after argument of this case in the Second Circuit, requires consideration of that argument as to both the 13% differential and the 11% surcharge. Although New York believes the Second Circuit was wrong in holding that HMOs are not insurers "as a matter of law," it does not argue the 9% assessment is saved from preemption because, unlike the 13% differential, the 9% regulates HMOs as providers of managed medical care, not as insurers.

[23] A proviso to the clause states that no ERISA plan "shall be deemed an insurance company. . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contract. . . ." 29 U.S.C. § 1144(b)(2)(B). This clause is known as the "deemer clause." The deemer clause is not implicated in this case because the district court enjoined enforcement of the laws against only HMOs and commercial insurers, and no self-insured fund filed a cross-appeal (A-90).

insurance industry, but must be specifically directed towards that industry." *Pilot Life*, 481 U.S. at 50.

In addition to the common-sense test, a court must look to what constitutes the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* *Pilot Life*, 481 U.S. at 48. Laws "aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the 'business of insurance.'" *United States Department of Treasury v. Fabe*, 113 S. Ct. at 2208, quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). Three factors are looked at to determine what constitutes the "business of insurance:"

> [F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno, 458 U.S. at 129. None of the three criteria, commonly known as the *Pireno* factors, is determinative of whether a law regulates insurance. *Id.*

Here, the 13% differential and 11% surcharge regulate insurance under both the "common-sense" test and the *Pireno* factors. Both the 13% and 11% are specifically directed at the insurance industry and seek to ensure the viable functioning of that industry by facilitating the transfer and spreading of risk by benefitting insurers which practice open enrollment and community rating. Although components of the hospital rate-setting methodology, both the 13% and 11% payor differentials are connected to a payor's status in the insurance marketplace and are imposed in connection with payors' risk-spreading practices. They, therefore, address matters typically considered to be the business of insurance, even though they do it indirectly through a hospital rate-setting statute.

Insurance has been defined as "an arrangement for transferring and distributing risk." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (citing R. Keeton, Insurance Law § 1.2(a) (1971)). The Court, discussing the legislative history of the McCarran-Ferguson Act, which preserves the power of the states to regulate the business of insurance, noted the right of states to control risks and rates in the insurance industry to ensure the viable functioning of the industry. *Id.* at 221-223.

The 11% surcharge was imposed only upon commercial insurers and was meant to remedy the problem of uneven and poorly distributed risk by preventing the continuing shrinkage of the Blue Cross community-rated pools. It, therefore, was specifically directed at the insurance industry. The 13% differential is imposed to account for the greater costs incurred by Blue Cross and HMOs as a result of their risk-spreading practices of open enrollment and community rating, which furthers New York's goals of making insurance coverage more widely available and reducing the number of uninsured people. Moreover, because it was meant to lower the hospital costs and, therefore, the rates of Blue Cross and HMOs, the 13% differential is directed at matters typically within insurance regulation.

The fact that HMOs receive the benefit of not paying the differential does not alter this conclusion. In holding that the 9% assessment does not fall within the insurance saving clause, the Second Circuit said that HMOs do not "as a matter of law" engage in the business of insurance because they are not required by New York law to be licensed as insurers (JA 60). However, as New York law makes clear, HMOs are hybrid entities; they perform both a health care provider function and an insurance function. They are governed by Article 44 of the Public Health Law in regard to their health care provider function and they are governed by the Insurance Law in regard to their insurance function.[24]

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[24] HMOs are subject to the general regulating authority of the Superintendent of Insurance, N.Y. Ins. Law § 1109(e), including: prior (continued...)

When HMOs offer health care to subscribers for a set fee and assume the risk that the actual cost of the services will be greater than the fee, they are engaged in the business of insurance. *See Matter of Estate of Medcare HMO*, 998 F.2d 436, 444-45 (7th Cir. 1993); *Ocean State Physicians' Health Plan, Inc. v. Blue Cross & Blue Shield*, 883 F.2d 1101, 1108, n.7 (1st Cir. 1989) *cert. denied*, 494 U.S. 1027 (1990). Likewise, when HMOs open-enroll their subscribers and set their premium using community rating, they are engaging in an insurance function. When a state law, such as the 13% differential, is directed at the insurance component of an HMO, it is directed at the business of insurance.

The McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, has two separate provisions which concern "the business of insurance." 15 U.S.C. § 1012(b). The first clause of that sub-section reserves to the states the power to regulate insurance and provides that federal law shall not "supersede any law enacted by any State for the purpose of regulating the business of insurance." *Id.* The second clause exempts the "business of insurance" from federal antitrust laws. *Id.*

Recently, the Court adopted a more expansive interpretation of the *Pireno* factors when evaluating state laws for preemption purposes under the first clause of § 1012(b) than when evaluating

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[24](...continued)
approval of premium rates and the public hearing requirements for changes in their premium rates, N.Y. Pub. Health Law § 4403(1) and N.Y. Ins. Law § 4308; examinations of their financial affairs by the Superintendent of Insurance, N.Y. Pub. Health Law § 4409(2); review of their subscribers' contracts by the Superintendent of Insurance, N.Y. Pub. Health Law §§ 4403(1)(h) and 4406(1); community rating and open enrollment, N.Y. Pub. Health Law § 4406(1) and N.Y. Ins. Law § 4317; assessments paid by insurers and HMOs to pay the expenses of the Insurance Department, N.Y. Ins. Law § § 1109 and 332; limitations on borrowing and pledging assets, N.Y. Ins. Law § 1307; and liquidation, rehabilitation and dissolution requirements, N.Y. Ins. Law § 1109; restrictions on investment, N.Y. Ins. Law § 1109(d).

laws for antitrust purposes under the second clause. *Fabe*, 113 S.Ct. at 2209-2210. The Court noted the different language and the different purpose of the two clauses. The first clause was intended to give states "broad regulatory authority" over the business of insurance; the second clause was intended "to carve out only a narrow exemption . . . from the federal antitrust laws." *Id.* at 2210.

The Court stated that the "broad" category of laws enacted for the purpose of regulating the business of insurance "consists of laws that possess the 'end, intention, or aim' of adjusting, managing or controlling the business of insurance." *Id.* This category of laws "necessarily encompasses more than just the business of insurance." *Id.* The Court also concluded that laws which protected the relationship between the insurer and insured indirectly were laws regulating the business of insurance. *Id.* at 2208.

The ERISA insurance saving clause serves the same policy as the first clause of § 1012(b), permitting the state regulation of insurance, since it was "designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. at 744, n. 21. The ERISA insurance saving clause concerns preemption of state laws regulating insurance and not protection of insurance companies from antitrust laws. The language of ERISA's saving clause is also broader than the narrow language of the antitrust exemption in the McCarran-Ferguson Act. It is not limited to "the business of insurance," but exempts all state laws "regulating insurance." 29 U.S.C. § 1144(b)(2)(A). Thus, the broader reading afforded to cases arising under the first clause of § 1012(b) applies to this case.

The 13% differential and the 11% surcharge meet all three of the *Pireno* factors that have been applied to determine what constitutes the business of insurance under the McCarran-Ferguson Act: they have the effect of transferring or spreading a policyholder's risk; they regulate an integral part of the policy relationship between the insurer and insured; and they are limited

to entities within the insurance industry. First, they are part of New York's regulatory effort to spread and distribute the risk of providing health insurance coverage. The 13% differential, between insurers who practice open enrollment and community rating and other insurers, benefits the insurers with the broader risk pools for the higher costs associated with insuring the poorer risks who, but for these practices, might be uninsured. It also allows them to continue to provide health care coverage at affordable prices to attract a large pool of varying risks. The 11% surcharge was intended to provide a benefit to Blue Cross vis-a-vis commercial insurance companies in order to stem the loss of low-risk subscribers from the Blue Cross risk pools, thereby allowing Blue Cross to maintain a mix of low, average and high risk subscribers. Thus, both the 13% differential and 11% surcharge spread risk.

The 13% differential and 11% surcharge also meet the second *Pireno* factor, albeit indirectly, by encouraging community rating and open enrollment. Community rating and open enrollment unquestionably play an integral role in the policy relationship between the insurer and the insured, by ensuring the formation of a policy relationship regardless of age, sex, health or occupational status and by determining that the price will be the same for all subscribers. Matters affecting the policy relationship between an insurer and the insured are not limited to the explicit terms contained in the insurance contract but extend to matters more broadly implicating the control of the business of insurance. *United States Department of Treasury v. Fabe*, 113 S.Ct. at 2209. In *Fabe*, the Court held that an Ohio liquidation statute which gave policyholders' claims a preference in the dissolution of a bankrupt insurance carrier affected the policy relationship between an insurer and the insured since it related to the ultimate performance of the contract in the event of liquidation. *Id.* In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 114 S. Ct. 597 (1993), the Fourth Circuit held that a Virginia law which regulated an insurance company's selection of providers to be included in a preferred provider plan met the second *Pireno* factor since the choice of a provider was related to treatment and cost which are important components of

health insurance. *Id.* at 503. Similarly, the differential and the surcharge are designed to ensure that health insurance policies are accessible and affordable to New Yorkers. They are integral to whether policyholders will receive insurance, from which carriers and at what price. Those factors are an integral part of the policy relationship between the insured and insurer.

Finally, the differential and the surcharge are limited to entities in the insurance industry. The 11% surcharge was limited to commercial insurers. The 13% differential is, in effect, a discount. All third-party payors of hospital bills, except those with open enrollment and community rating, pay 113% of the DRG rate. All third-party payors of hospital bills are acting as insurers of patients. The fact that the insurance marketplace may involve hospitals, patients and others does not make the differential and the surcharge any less limited, since the determining factor is the insurers' role in the insurance marketplace.

CONCLUSION

For the reasons set forth, the Court should reverse the judgment below.

Dated: New York, New York
November 15, 1994

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Nos. 93-1408, 93-1414, and 93-1415

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IN THE
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OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 (ERISA) preempts the New York all-payor hospital reimbursement system to the extent that the system provides, irrespective of ERISA status, one set of rates for patients covered by Medicaid, Blue Cross plans and health maintenance organizations ("HMOs") and another set of rates for patients covered by other third-party payors, including commercial insurers, because the different rates may affect ERISA plans' costs or their choice of coverage.

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the decision of the United States Court of Appeals for the Second Circuit, which is contained in the separately-bound joint Appendix to the Petition at pages A-1 to A-2. Because of the numerosity of the parties, the list will not be reproduced herein.

In accordance with Supreme Court Rule 29.1, Petitioner Hospital Association of New York State states that it does not have a corporate parent or subsidiaries, other than wholly-owned subsidiaries.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

Nos. 93-1408, 93-1414 and 93-1415

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

OPINIONS BELOW

The amended opinion of the United States Court of Appeals for the Second Circuit is reported at 14 F.3d 708. It is reprinted in the separately-bound joint Appendix to the Petition at A-1 to A-34. The opinion of the United States District Court for the Southern District of New York is reported at 813 F. Supp. 996. It is reprinted in the separately-bound joint Appendix to the Petition at A-63 to A-90.

JURISDICTION

The judgment of the court of appeals was initially entered on October 25, 1993. On January 12, 1994, the court of appeals granted a petition for rehearing, and on January 14, 1994, the court entered a new judgment and amended opinion. The petition for a writ of certiorari was filed on March 9, 1994, and was granted on October 7, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS

The relevant statutory provisions are:

(a) ERISA § 514(a) (codified at 29 U.S.C. § 1144(a) (1988)), which provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) ERISA § 514(b)(2)(A) (codified at 29 U.S.C. § 1144(b)(2)(A) (1988)), which provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to ex-

empt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(c) N.Y. Pub. Health Law § 2807-c(1)(a) (McKinney 1993), a copy of which is set forth in the joint Appendix to the Petition at A-101 to A-102.

(d) N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993), a copy of which is set forth in the joint Appendix to the Petition at A-102 to A-103.

STATEMENT

Pursuant to its constitutional mandate to protect and promote the health of its inhabitants (N.Y. Const. art. XVII, § 3), New York has long engaged in the comprehensive regulation of the activities of hospitals, including the rates they charge. While the methodologies for setting in-patient hospital rates have evolved to reflect changes in the industry, the objectives have remained constant: to provide all patients with access to the highest quality of care; to ensure that hospitals receive adequate revenue; to contain the costs of hospital care; and to distribute the costs of hospital care equitably among all payors. The question presented here is whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, preempts efforts by New York to meet these objectives by setting different rates for different categories of patients. The court of appeals held that the New York law was preempted because the different rates could substantially increase the costs to ERISA plans or affect the choices made by ERISA plans about coverage for hospital services.

1. *Hospital Reimbursement Methodology In New York.*

The present hospital reimbursement system in New York is a case-based system. Like Medicare and healthcare systems in many other States, it directs hospitals to charge fixed rates for each patient treated, based upon the

patient's diagnosis rather than the actual cost of the services performed. Under this system, each medical diagnosis falls into one of 794 categories, known as diagnostic related groups ("DRGs"). J.A. 152. Each DRG, in turn, is assigned a specified rate, which is generally based on the expected average cost incurred by all hospitals to treat a patient in that DRG. J.A. 152. Because hospitals receive predetermined amounts for each service, regardless of the actual resources expended to treat a patient, the DRG system has a built-in incentive for hospitals to employ their resources efficiently and to contain costs.

While the 794 DRG categories are fixed across the State, the actual case-based rates for each DRG category vary among all hospitals in the State. Each of the separate 794 DRGs for each hospital is based on myriad components, many of which are hospital-specific. These components include the hospital's historical operating costs, the total number of patients that the hospital treats annually, the total number of Medicare patients that the hospital treats annually, whether the hospital is a teaching facility, and whether the hospital is located in New York City or upstate, or in a rural community. J.A. 250-53.

2. a. *The 13 Percent Differential.*

Once the case-based rates are calculated for a particular hospital, Section 2807-c(1)(a) of the New York Public Health Law requires that the hospital bill its patients covered by Medicaid, Blue Cross plans, and certain Health Maintenance Organizations (HMOs) at that basic rate. *See* Pet. App. A-101 to A-102. Section 2807-c(1)(b), in contrast, requires the hospital to bill other patients at a rate that is 113% of the basic rate. *See* Pet. App. A-102 to A-103. The patients subject to the higher rate include patients covered by commercial insurance, as well as those covered by workers' compensation, the volunteer firefighters' benefit system, the volunteer ambulance workers' system, the "no-fault" motor vehicle insurance system, and

self-insured funds. *See* Pet. App. A-102 to A-103.[1] It is this 13% differential that the commercial insurers have challenged in this action.[2]

While this action represents the first time that any commercial insurer has challenged the differential, the differential is a long-standing part of the hospital reimbursement system in New York. Differentials between the rates charged to patients covered by Blue Cross and by Medicaid and the rates charged to other patients have existed for years in New York (J.A. 148), first as a matter of practice, and then as a matter of law. J.A. 148-50. The difference in rates charged to Medicaid patients and insureds of Blue Cross, as opposed to other patients, takes into account the special burdens that these payors have assumed in pursuit of the State's efforts to assure affordable health care for all its residents.

The burdens historically assumed by Blue Cross are numerous and important. Unlike commercial insurers,

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[1] Patients not covered by either subsection (a) or subsection (b) make payments "on the basis of the hospital's charges," N.Y. Pub. Health Law § 2807-c(1)(c); *see* Pet. App. A-103, subject to a maximum of 120% of the rate set forth in subsection (b). *Id.*

[2] Some respondents (the commercial insurers) also challenged a temporary 11% assessment under N.Y. Pub. Health Law § 2807-c(11)(i), imposed only on hospital bills of patients covered by commercial insurance, and not other types of third-party payors. This 11% assessment became effective in April 1992 and expired in March 1993. Unlike revenue from the 13% differential, the revenue generated by the 11% assessment was ultimately paid to the State, not to hospitals.

Unlike the commercial insurers, the HMO respondents took no position on the 13% differential. They have challenged, however, an assessment of up to 9% under N.Y. Pub. Health Law § 2807-c(2-a)(a)-(e), applying to hospital bills for patients covered by certain HMOs that fail to enroll a certain number of Medicaid recipients. Despite differences in the operation and purposes of the three statutes, the courts below have treated the 13% differential and the 9% and 11% assessments identically under their ERISA preemption analyses. In this brief, we address only the 13% differential.

Blue Cross plans have traditionally offered insurance to sick or elderly individuals who were unable to obtain insurance from other sources (open enrollment), charged premiums to subscribers based on the overall experience of the community instead of a particular subscriber's own medical experience (community rating), and provided advance payments to hospitals. J.A. 161-68. These policies, among other things, helped to reduce the number of charitable care patients that hospitals must serve. The State has recognized that, absent some special considerations for undertaking these public burdens, Blue Cross plans could not effectively compete for the business of healthier segments of the population. That inability, in turn, would threaten the viability of the Blue Cross plans, the availability of insurance for high-risk persons, and ultimately the stability of hospitals that depend upon predictable and adequate revenues. J.A. 163.

Prior to 1978, the rates paid to hospitals by Blue Cross were substantially lower than the rates paid by other payors. As the disparity in the rates reached 36%, the State in 1978 enacted legislation that temporarily froze hospital rates until the State could study fairer methods for all payors, including commercial insurers. J.A. 243. In 1982, following an extensive review of hospital financing, the State enacted its first comprehensive hospital reimbursement statute, called the New York Prospective Hospital Reimbursement Methodology ("NYPHRM I"), to take effect in 1983. The overall goal of NYPHRM I was to establish a fully integrated reimbursement system, encompassing all classes of payors, that would provide adequate revenue to hospitals while promoting efficient use of resources and widespread access to health care. J.A. 150. Integral to this all-payor system was a statutory limitation on the differential in hospital rates, which was set between 12% and 15%. J.A. 243-44.

Recognizing the effectiveness of that type of comprehensive health care regulation, the Secretary of Health and Human Services in 1982, pursuant to Congress' authoriza-

tion, elected to reimburse hospitals for services to Medicare patients under rates set by NYPHRM I. 42 U.S.C. § 1395b-1. As a result, the rates charged to Medicare, which otherwise would have been set by federal law, were set, subject to an upper limit, by New York law.[3] That same year, Congress substantially reformed the Medicare system for the rest of the country. New York was exempted, however, due to participation by Medicare in NYPHRM I.[4]

In 1985, NYPHRM I expired and NYPHRM II was enacted, covering in-patient hospital reimbursement from 1986 through 1987. NYPHRM II limited the disparity for in-patient hospital rates among payors to no more than 12%. J.A. 246. In 1988, the State enacted NYPHRM III, which governed hospital reimbursement from 1988 through 1990. NYPHRM III changed the all-payor hospital reimbursement methodology to a DRG-based system, with a 13% differential between the rates for patients covered by Medicaid, Blue Cross, and HMOs and the rates for patients covered by other third-party payors. J.A. 248. In 1990 the State enacted NYPHRM IV, which continued the all-payor DRG system and the 13% differential.[5]

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[3] Pursuant to NYPHRM I, the rates charged to Medicare were the same discounted rates charged to Medicaid and Blue Cross patients, which were lower than the rates charged to patients covered by commercial insurance. N.Y. Pub. Health Law § 2808-c(1).

[4] NYPHRM I was challenged on ERISA preemption grounds in *Rebaldo v. Cuomo*, in which the Second Circuit held that the right of the State to set rates for participants in ERISA plans, along with all other patients, was not preempted. 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). In its *Travelers* decision, the Second Circuit held that the reasoning in *Rebaldo* was no longer valid, after the decision of this Court in *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). See Pet. App. A-21.

[5] After the filing of the lawsuit, New York enacted NYPHRM V, which again continued the 13% differential for all payors (except workers' compensation).

b. *The 13 Percent Differential and ERISA Plans.*

Members of "employee welfare benefit plans" under ERISA are among the patients receiving in-hospital care in New York. "An 'employee welfare benefit plan' includes any program that provides benefits for contingencies such as illness, accident, disability, death, or unemployment." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 n.5 (1983) (citing 29 U.S.C. § 1002(1)).

The 13% differential operates without regard to whether a patient is or is not a participant in an ERISA plan. As the terms of the law make clear, application of the 13% differential depends entirely upon the form of coverage that the patient carries. The effect of the law is thus exactly the same for patients who purchase insurance directly as for patients who are members of ERISA plans. For example, a patient covered by Blue Cross will be billed the prescribed rate under Section 2807-c(1)(a) whether or not that patient participates in an ERISA plan. Similarly, under Section 2807-c(1)(b), a hospital will bill 113% of the DRG rate to patients covered under other arrangements, including commercial insurance, whether or not the patient is a participant in an ERISA plan.

Like other consumers, ERISA plans may choose among different forms of coverage for their members. For example, an ERISA plan may decide to obtain coverage from Blue Cross (which pays hospitals at the DRG rate); to obtain coverage from commercial insurers (which pay at 113% of the DRG rate); to obtain coverage by an HMO (which pays either at the DRG rate or at a negotiated rate)[6]; or to self-insure.[7] If an ERISA plan elects

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[6] Under New York law, HMOs are the only payors permitted to negotiate their payments to hospitals. N.Y. Pub. Health Law § 2807-c(2)(b)(i).

[7] A plan need not elect a single form of coverage for all employees. Indeed, it is typical for larger employers, as part of their plans, to offer employees the choice of HMO, commercial or Blue Cross coverage, each with its own set of benefits and costs.

to self-insure, it may either pay the hospital directly (at 113% of the DRG rate) or choose to pay indirectly, *e.g.*, issue a two-party check with the patient and the hospital as payees. In the latter case, the plan pays the hospital's statutorily-capped charges, which may be higher or lower than the case-based rate. N.Y. Pub. Health Law § 2807-c(1)(c).[8]

3. ***The Proceedings Below.***

a. Respondent The Travelers Insurance Company initially commenced a declaratory judgment action against the State petitioners seeking, *inter alia*, to invalidate the 13% differential, as applied to commercial insurers, on ERISA preemption grounds. This suit was followed by a second action, brought by Respondent Health Insurance Association of America and other insurance trade associations and individual insurance companies, also seeking a declaratory judgment invalidating the 13% differential under ERISA. Petitioner HANYS and petitioners New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively referred to herein as "Blue Cross") intervened in both actions as defendants. Respondents New York State HMO Conference and Health Services Medical Corporation and eleven individual HMOs then intervened in both actions as plaintiffs. The district court subsequently consolidated the two actions.

The district court granted summary judgment in favor of respondents, and enjoined the State of New York from enforcing the 13% differential against any commercial

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[8] There are other options as well. The New York law further includes an incentive targeted solely to payors that pay at the "commercial" rate and payors that pay charges: if the commercial insurer or charge payor pays the hospital bill in full within ten days, it may take a 2% discount off the payment. N.Y. Pub. Health Law § 2807-c(11)(e). The discount is not available to Blue Cross or to HMOs. Also, an ERISA plan may take itself out of the statute by paying a defined monetary benefit, which then is not affected at all by the differential.

insurer in connection with its coverage of an ERISA plan. The court first acknowledged that "the Surcharges do not directly increase a plan's costs or effect the level of benefits to be offered." Pet. App. A-71. It went on, however, to state that "the Surcharges at issue will have a significant effect on the commercial insurers and HMOs which do or could provide coverage for ERISA plans and thus lead, at least indirectly, to an increase in plan costs." Pet. App. A-71 (footnote omitted). The court also pointed to the justification for the law—"that the Surcharges will increase the cost of obtaining medical insurance through any source other than [Blue Cross] to a sufficient extent that customers will switch their coverage to and ensure the economic viability of [Blue Cross]" (Pet. App. A-72)—as a basis for concluding that "even if the exact economic effect of the Surcharges cannot be determined at this stage in the litigation, . . . that effect is intended to be and is in fact substantial." Pet. App. A-73.[9] Having thus found that the law "relates to" ERISA plans within the meaning of the ERISA preemption provision, the court found that it was not a law "regulat[ing] insurance" within the meaning of the ERISA savings clause. Pet. App. A-88.

b. The court of appeals affirmed.[10] Applying the two-part test developed by this Court, *see, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990), the court of appeals conceded that "the challenged statutes do

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[9] The district court also said that the 13% differential diverts ERISA plan resources to a state-specified use unrelated to the health care of plan participants, Pet. App. A-74, and that, because hospital rates in other States may not include this cost, the statute creates potentially inconsistent obligations upon multi-state ERISA plans. *Id.* at A-74 to A-75.

[10] The Second Circuit had issued an earlier opinion which, for all intents and purposes here, was identical to its Amended Opinion. Because the earlier opinion did not address certain issues unrelated to this appeal, HANYS and other petitioners petitioned the Second Circuit for a rehearing.

not refer to ERISA plans." Pet. App. A-22. It held, however, that their "indirect economic impact upon ERISA plans" was enough to "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand*." Pet. App. A-22.

The court of appeals recognized that the New York law served a number of related purposes, stating: "[t]he 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers. In particular, the differential was meant to level [the] playing field for the Blues in their competition with commercial insurers." Pet. App. A-7 to A-8 (internal quotations omitted). Although the court did not find that any of these policies was itself incompatible with ERISA, it nonetheless determined that the differential impermissibly "increase[s] the cost to ERISA plans of providing beneficiaries with a given level of health care benefits." Pet. App. A-23. Moreover, the court found that, in setting different rates for different patients according to their types of coverage, the surcharge "purposely interfere[s] with the choices that ERISA plans make for health care coverage" by making Blue Cross coverage more competitive with other health care coverage. *Id.* at A-22. Rejecting the contention that an indirect economic impact, by itself, is not sufficient to justify preemption under ERISA, the Second Circuit relied on a district court decision, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 U.S. Dist. Lexis 2011 (S.D.N.Y. Feb. 18, 1993), *reversed*, 27 F.3d 823 (2d Cir. 1994), for the proposition that "a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." Pet. App. A-24.

The court of appeals also ruled that the 13% differential is not saved from preemption by the ERISA savings clause. Having earlier said that the New York statutes

"purposely" sought to influence choices about coverage, Pet. App. A-22, the court took the view, for purposes of the savings clause, that the differential "aim[s] to regulate hospital rates." Pet. App. A-27. Furthermore, the court decided, the New York law satisfied only one of the three factors (the "McCarran-Ferguson factors") used to determine whether a law regulates insurance. Although the law did "help spread the risk of health care costs," Pet. App. A-28, it did not "regulate any practice that is integral to the insurer-insured relationship," *id.*, nor was it " 'limited to entities within the insurance industry.' " Pet. App. A-29 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49 (1987)).[11]

INTRODUCTION AND SUMMARY OF ARGUMENT

The court of appeals held that ERISA required preemption of a New York law that established one set of hospital rates for patients covered by Blue Cross, HMOs, and Medicaid, and a different (higher) set of rates for other patients, including those covered by commercial insurers and self-insured funds. Although the court accepted that the law was one of general application—and thus made no distinction between members of ERISA plans and other hospital patients—it nonetheless concluded that the "indirect economic impact upon ERISA plans" (Pet. App. A-22) was enough to warrant preemption. According to the court, the law was invalid under ERISA because (for plans choosing coverage subject to the higher rates) it "substantially increase[s] the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," Pet. App. A-23, and because, solely as a result of the different rate levels, it "purposely interfere[s] with the choices that ERISA plans make for health care coverage." Pet. App. A-22. The court then went on to reject the argument that the law

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[11] The Second Circuit also rejected defenses based upon the Tax Injunction Act, raised by other petitioners, and laches on the 13% differential, raised by HANYS.

was saved from preemption under ERISA as a law "which regulates insurance." Pet. App. A-25 to A-29.

This analysis extends preemption under ERISA past any logical breaking point. Although ERISA contains a broad preemption clause, it cannot reasonably be applied to any and all generally-applicable state laws that, simply by affecting the cost of particular goods and services, have an "indirect economic impact" on ERISA plans. To the contrary, the history of the preemption provision gives no indication that "the field of private employee benefit programs"—the "field" from which state authority was displaced—was to include laws indirectly affecting the costs of ERISA plans. And, it is especially unlikely that Congress intended the general preemption provision of ERISA to displace traditional state authority over the regulation of health care (including hospital rates), given Congress' longstanding recognition of the States' responsibility for assuring adequate medical care for their citizens. This conclusion is reinforced by Congress' awareness of, and federal participation in, state programs that set different rates for different categories of payors, including commercial insurers.

The fact that ERISA plans have a choice of subscribing to Blue Cross (and thus potentially benefiting from the differential) does not make the New York law invalid. If States may shift costs among various payors—as respondents apparently concede that they may—it would make little sense to say that they may *not* do so whenever ERISA plans might be able to take advantage of the more favorable rates. It would make even less sense in the circumstances here, given that the differential favoring patients of Blue Cross merely reflects Blue Cross' historical assumption of burdens not assumed by commercial insurers and other payors. The New York law is thus quite the opposite of laws found to "relate to" ERISA plans on the ground that they *denied* employers or their plans the right to choose the benefits to be provided to

their employees. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

Even if state laws affecting costs can be said to "relate to" ERISA plans, however, the decision below is still incorrect. It is wholly inconsistent for the court of appeals to assert that the particular law here, by setting different rates for patients of different payors, impermissibly affects the choice of health care coverage and, yet, simultaneously deny that the law "regulates insurance" (and is thus within the ERISA savings clause). Moreover, if the law is regarded as "purposely interfer[ing]" with choices about insurance coverage, it plainly meets the criteria utilized by this Court for deciding whether a law falls within the ambit of the savings clause. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 743-44. Not only does it regulate the spreading of risk, but, contrary to the holding below, it regulates an integral part of the relationship between insurer and policyholder and is limited to those subject to insurance regulation. Thus, if the court of appeals is correct that the law is within the scope of the preemption clause, it is wrong that it is outside the scope of the savings clause.

ARGUMENT

I. ERISA DOES NOT PREEMPT GENERAL STATE LAWS MERELY BECAUSE THEY HAVE AN INDIRECT ECONOMIC IMPACT ON ERISA PLANS

This Court has frequently observed that, in determining the preemptive effect of federal law, the " 'ultimate touchstone' " is congressional intent. *See, e.g., Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). Although this inquiry naturally focuses on the language of the statute itself, *United States v. Alvarez-Sanchez*, 114 S. Ct. 1599, 1603 (1994), it is "guided by respect for the separate spheres of governmental authority preserved in our federalist system." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). Construction of a federal statute thus begins "with an assumption that the historic police powers of the States [are] not to be superseded . . . unless that [is] the clear and manifest purpose of Congress." *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). And this presumption against preemption applies in two important aspects: first, it is employed to determine whether the federal law provides for preemption at all; and, second, it is used to identify what the scope of any preemption must be. *See Department of Revenue v. ACF Indus., Inc.*, 114 S. Ct. 843, 850 (1994) ("When determining the breadth of a federal statute that impinges upon or pre-empts the States' traditional powers, we are hesitant to extend the statute beyond its evident scope.").

It is well-recognized, of course, that ERISA has broad preemptive scope. *See, e.g., District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 584 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139; *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983). The statute has an express preemption provision—declar-

ing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA (29 U.S.C. § 1144(a))—and this Court has often described the language of that provision as "'deliberately expansive.'" *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). Applying that language, the Court has set forth a two-part test: a state law is preempted "'if it has a connection with or reference to [an ERISA] plan.'" *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988).

The court of appeals acknowledged that the New York law "do[es] not refer to ERISA plans" (Pet. App. A-22); it held, rather, that it ran afoul of "the less stringent 'connection with' standard . . . ." Pet. App. A-22. Under that standard, it is accepted that, to be preempted, a state law need not be "specifically designed" to affect ERISA plans. *See Ingersoll-Rand*, 498 U.S. at 139. While recognizing that many state laws of general application would have "only a 'tenuous, remote, or peripheral' connection with covered plans," *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n.1 (quoting *Shaw*, 463 U.S. at 100 n.21), this Court has held that state laws are preempted insofar as they establish certain rights and obligations with respect to ERISA plans. In particular, the Court has found preemption of state laws that, on their face or as specifically applied, define the duties owed by employers or their plans. See *Alessi* (duty to pay plan participants pension benefits without offset for workers' compensation); *Shaw* (duty to provide plan participants with coverage for pregnancy); *Pilot Life* (duty to process plan participants' benefit claims in accordance with state standards); *FMC Corp.* (duty to pay plan participants' benefit claims without subrogation); *Ingersoll-Rand* (duty

not to discharge employees to avoid payment of benefits).[12]

This Court has never held, however, what the court below held: that ERISA requires preemption of a generally-applicable state law on the sole ground that it has an "indirect economic impact upon ERISA plans." Pet. App. A-22. To the contrary, in the most analogous case, the Court concluded that ERISA did *not* bar application of a general state garnishment law, despite its express recognition that the law imposed "substantial administrative burdens and costs" on ERISA plans. See *Mackey*, 486 U.S. at 831. *See also Ingersoll-Rand*, 498 U.S. at 139 (noting that in *Mackey* "[t]he fact that collection might burden the administration of a plan did not, by itself, compel pre-emption"). The Court has subsequently made clear that preemption does not extend to "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.[13]

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[12] In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court found that a state law had a connection with ERISA plans because it effectively required employers to provide their employees with specified mental health coverage. The Court then concluded, however, that the law was saved from preemption to the extent that it applied to agreements between ERISA plans and their insurers. 471 U.S. at 739-47.

[13] In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court also held that ERISA did not preempt a state law requiring severance payments, which ordinarily fell within the purview of ERISA, because the law did not require the establishment or maintenance of an on-going plan. According to the Court, the mere fact that the cost of complying with the state law might, in turn, indirectly affect the decisions of an employer in creating or structuring its plans was no different from any other general financial obligation, and simply too far removed to have a connection to a plan. *Id.* at 14. *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 741 (stating that although a state law which mandates insurers to provide certain benefits relates to ERISA plans, state laws that "regulate such matters as the way in which insurance may be sold" to insureds, including ERISA plans, does not relate to ERISA plans.)

These principles should be controlling here. As we discuss below, it would be irrational to read the ERISA preemption clause to prohibit the States from regulating hospital rates in general, or from shifting costs among classes of hospital patients in particular, merely because that regulation would have an indirect economic impact on ERISA plans. Nor is that reading made any more rational by the fact that regulation of rates may influence ERISA plans' choices about coverage. As Congress is well aware, States commonly act to assure that the costs of health care are reasonably allocated among those needing services, and that action is not rendered invalid simply because, under a particular regulation, ERISA plans (like everyone else) may have the option of benefiting from a particular allocation rather than bearing the burden of it. Thus, while preemption under ERISA is concededly broad, it does not grant ERISA plans immunity from the economic effects of state laws apportioning the costs of health care among all recipients.

A. Nothing in ERISA Justifies Widespread Preemption of General State Laws Affecting the Costs to ERISA Plans.

It might be possible, as a literal matter, to read the phrase "relates to" to encompass any state law having an indirect economic impact on ERISA plans. But there is little reason to adopt that reading, and a number of important reasons to reject it. *See Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) ("ERISA's preemption provision is very broad, but the word 'related' must not be taken literally").

As an initial matter, to preempt all generally-applicable state laws merely affecting (or, even, substantially affecting) the costs of an ERISA plan would result in a significant reallocation of federal and state authority.[14] Apply-

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[14] Given that ERISA plans must operate as commercial entities, it seems obvious that a vast array of state laws will have, in one form or another, a significant economic impact on ERISA plans.

ing the usual presumption against that restructuring, *see Cipollone*, 112 S. Ct. at 2617, it is reasonable to expect that, if Congress intended so wide-ranging a displacement of state law, it would have made that intention clear on the face of the statute or, at least, in the legislative history. *See Massachusetts v. Morash*, 490 U.S. 107, 119 (1989) ("[a]bsent any indication [in ERISA] that Congress intended such far-reaching consequences, we are reluctant to so significantly interfere with 'the separate spheres of governmental authority preserved in our federal system' ") (quoting *Fort Halifax*, 482 U.S. at 19).[15] Yet, even giving due weight to the "deliberately expansive" language of its preemption clause, ERISA contains little evidence that preemption of state law was to extend so far. To the contrary, the broad language of Section 514(a) was added late in the legislative process, and the legislative history—while indicating that it was intended to reserve to the federal government "the sole power to regulate the field of employee benefit plans," 120 Cong. Rec. 29,197 (1974) (Rep. Dent)—gives no hint that the

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Some laws (*e.g.*, laws affecting commercial real estate) may substantially raise the costs of an ERISA plan; other laws that operate against the employer (*e.g.*, environmental laws) may reduce the funds available for contribution to an ERISA plan. And, of course, certain laws provide for the closing down of businesses, such as nursing homes, unable to meet specified standards. *See, e.g.*, N.Y. Pub. Health Law § 2806. All these laws would seem to be preempted under the reasoning of the decision below.

[15] As this Court has observed, the principal protection afforded to States against displacement of their authority by the national government lies in "procedural safeguards inherent in the structure of the federal system." *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 552 (1985). Those safeguards cannot operate effectively, however, if federal laws preempting traditional state authority fail to contain a clear indication, not just of some intention to preempt, but of the degree of the preemption. *See Alessi, supra*, 451 U.S. at 522 (preemption must be "unmistakably so ordained"). And, we submit, the more unusual the degree of displacement, the more certain the indications of congressional intention must be.

"field" was to encompass any and all laws indirectly imposing costs on ERISA plans.

The original House and Senate bills provided only for preemption of state laws relating to the particular matters addressed by ERISA.[16] Under those bills, therefore, ERISA would not have preempted a state law that regulated the form, amount, or structure of plan benefits, provided that it did so in a manner as to which ERISA is silent. However, concerned that this formulation would open "the door to multiple and potentially conflicting state laws hastily contrived to deal with some particular aspect of [ERISA plans] not clearly connected to the federal regulatory scheme," the Conference Committee ultimately opted for the broader language currently found in ERISA. 3 Legislative History 4770-71. Thus, instead of preempting only those state laws dealing with matters on which ERISA has spoken, the Conferees agreed that ERISA would displace all "State action in the field of private employee benefit programs." 3 Legislative History 4771.

There is no indication, however, that the Conferees regarded "the field of private employee benefit programs" as vast enough to encompass general state laws having nothing more than an indirect economic effect on ERISA plans.[17] Citing examples of state laws that would be pre-

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[16] The House bill stated that ERISA would supersede laws that "relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies." H.R. 2, 93d Cong., 2d Sess., § 514(a) (1974), *reprinted in* 3 Senate Committee on Labor and Public Welfare, Legislative History of the Employee Retirement Income Security Act of 1974, at 4657-58 (Committee Print 1976) ("Legislative History"). The Senate bill stated that ERISA would preempt state laws that "relate to the subject matters regulated by this Act." H.R. 2, 93d Cong., 2d Sess., § 699(a) (1974), 3 Legislative History 3820.

[17] Had the preemption provision not been broadened, the laws at issue in *Alessi*, *Shaw*, and *FMC Corp.*—to take several examples—would likely not have been preempted. Nothing in ERISA addresses

empted, the Conference Report referred to state laws directly pertaining to employee benefit plans. These examples included "State laws compelling disclosure from [ERISA] plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans—unless a criminal statute of general application —[and] establishing State termination insurance programs." 3 Legislative History 4771. Furthermore, the Conferees indicated that, in light of the preemption of State law, "a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.* But that field—"issues involving rights and obligations" under ERISA plans—is quite different from, and less open-ended than, a field encompassing laws that, by regulating the price of various goods and services, simply have an indirect effect on the financial operations of employee benefit plans.

Other parts of the legislative history confirm that point. Following his oft-cited statement that ERISA's "crowning achievement [was] the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans," *see, e.g., Shaw*, 463 U.S. at 99; *Pilot Life Ins. Co.*, 481 U.S. at 46, Representative Dent, a sponsor of ERISA, explained that its preemption provision was patterned after the approach employed in the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e *et seq.*); 3 Legislative History 4670. Significantly, however, the Health Maintenance Organization Act preempts only certain enumerated state actions that impair the formation and operation of HMOs, and not any and all state actions that might affect HMOs.[18] 42 U.S.C. § 300e-10. And,

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the issues of offsetting workers' compensation payments, or providing coverage for pregnancy, or requiring subrogation of rights in return for payment of benefits.

[18] Section (a) of the preemption provision states:

during the floor debates, Senator Javits, another sponsor of ERISA, explained that, while ERISA would preempt bar association rules regulating the "form and content" of an ERISA legal services welfare plan, it would *not* preempt ethical rules and guidelines and disciplinary actions that apply to attorneys providing services to such plans. 3 Legislative History 4789. These sponsors, therefore, strongly suggested that preemption under ERISA would reach any state laws that affect ERISA plans by regulating the form and content of their benefits, but would not extend to other state laws that might indirectly affect the operation of ERISA plans.

(a) Restrictive State laws and practices.

In the case of any entity

(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, or

(E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, and

(2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans)

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

The legislative history does make clear that preemption was intended to advance "the interests of uniformity with respect to interstate plans . . . ." 3 Legislative History 4771. Indeed, this Court has specifically identified "the threat of conflicting or inconsistent State and local regulation" as "the problem that the pre-emption provision was intended to address." *Fort Halifax*, 482 U.S. at 9 (quoting 120 Cong. Rec. 29,197, 29,933 (1974) (Rep. Dent)). But an interest in "uniformity" does not lead to preemption of state laws affecting the costs of ERISA plans. If preemption of a particular state law is to serve that interest, it is necessary that the law regulate an area in which uniformity might otherwise be expected. That is hardly the case with respect to the costs of an ERISA plan: with or without preemption of state law, those costs will vary widely from state to state, as the costs of health care and its coverage vary dramatically from state to state. Thus, the broad rationale adopted by the court of appeals would lead to extensive preemption of state law without advancing any legitimate interest protected by ERISA. *See generally Fort Halifax*, 482 U.S. at 8-15.

B. ERISA Does Not Preempt Traditional State Authority To Regulate Hospital Rates.

It is true that the *holding* of the decision below, as opposed to its *rationale*, applies to a law regulating the cost of one particular good or service: *i.e.*, in-hospital care. But we see no grounds for saying that States may have laws affecting the price of some goods and services purchased by ERISA plans, but not in-hospital care. Although the court of appeals remarked that the New York law "substantially increase[d] the cost to ERISA plans of providing beneficiaries with a given level of health care benefits" (Pet. App. A-23), that statement, even if correct, does not provide a basis for distinguishing hospital costs from other costs: *any* expenditure by a plan ultimately reduces the funds available to provide benefits. Put another way, if the test for preemption were

whether an ERISA plan could offer more benefits in the absence of a particular state law, very few state laws would be able to escape preemption.

In any event, a reading of ERISA that preempted any state law affecting the costs of health care, or even hospital care, would be far too broad. Given the important role of ERISA plans in providing health care coverage, *see* Pet. App. A-6, it follows naturally that the most garden-variety regulation of hospitals will have an indirect economic effect—often a substantial effect (*see* Pet. App. A-24)—on ERISA plans. For example, New York (like many States) establishes requirements for the staffing of hospitals, sets quality assurance standards, and imposes obligations for disposal of medical waste, each of which forces hospitals to incur costs that are built into their rates. Indeed, the impact of many of these laws on hospital rates (and, potentially, on insurance premiums) is far greater than the impact of the differential here. Thus, if the court of appeals were correct that indirect economic effects were enough to require preemption, state regulation of hospital care would be severely curtailed.[19]

Seeking to avoid that uncomfortable result, respondents try to narrow the decision below in a manner that, in the

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[19] It is undisputed that members of ERISA plans are significant consumers of hospital services. They are not, however, the predominant users of in-patient hospital services. Although the court of appeals stated that "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans," Pet. App. A-6, that figure is somewhat misleading for several reasons. First, though not clear from the awkward wording, it excludes patients without "private health care insurance" (*e.g.*, Medicaid). Second, it refers to the market share of ERISA plans for *all* health care coverage—which includes outpatient, physician, and other non-hospital services, not just the in-patient services at issue here. And, finally, it specifically excludes Medicare or other elderly patients, who are the most extensive users of *hospital* services. To the extent that it might be relevant, ERISA plans cover approximately 25 percent of all in-patient services in New York.

end, aptly demonstrates its inherent irrationality. While respondents argue that *this* law is preempted, they take the position that a law simply setting the rates for hospital service would *not* be preempted. *See, e.g.*, Br. in Opp. 4, 6, 13, 18; C.A. Br. 1, 17. But this concession is openly at odds with the theory that state laws are preempted because, by affecting costs, they have a "connection with" ERISA plans. By that standard, the DRG rates themselves "affect" the costs of ERISA plans in the most unequivocal way: by establishing the actual price to be paid for particular in-hospital procedures.

The court of appeals, for its part, seemed concerned that the New York law set rates unequally: that is, that it increased the rates of certain patients, but not others. But the imposition of different rates does not turn a valid law into an invalid one. To start with, it is flatly inconsistent with the preemption provision itself to make preemption turn on whether a law has an *adverse* effect on ERISA plans. That provision does not draw a line between state laws that increase the price of services purchased by ERISA plans and laws that decrease the price of services purchased by plans; as a matter of simple statutory interpretation, either type of law "relates to" ERISA plans in the same manner. And, this Court has expressly held that ERISA, where it properly applies, preempts even laws beneficial to ERISA plans. *See Mackey*, 486 U.S. at 829-30.[20]

In any event, the setting of higher rates to offset lower charges to particular patients does not, in and of itself, require preemption of state law. Once again, respondents

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[20] We note that respondents do not challenge several components of the New York rate-setting statute that operate to their benefit. For example, they do not challenge the right of HMOs (but not other payors) to negotiate payments to hospitals, *see* note 6 *supra*, presumably because commercial insurers are setting up their own HMOs. Nor do they challenge the 2% discount offered to commercial insurers (but not Blue Cross or HMOs) for payment to hospitals within 10 days. *See* note 8 *supra*.

ultimately concede this point: in this Court they have emphasized that they are *not* claiming preemption of laws increasing charges to certain patients to take account of patients unable to pay the regular charges. *See* Br. in Opp. at 4, 18. But this concession, too, seriously undercuts their position, for, at least insofar as complaints about added costs to ERISA plans are concerned, it makes no difference whatever that the reallocation of costs benefits charitable patients (in the DRG rates themselves), or Medicaid patients (in the differential), or patients of Blue Cross (in the differential). In each case, the State is simply recognizing that certain payors for different classes of patients—often those with lesser resources or a greater need for services—should not be required to bear an equal share of the overall costs.

It is likewise instructive that respondents do not challenge the differential to the extent that it imposes lesser costs on Medicaid. To challenge that differential, of course, respondents would have to take the dubious position that Congress meant to limit States to setting *identical* hospital rates for all patients, regardless of individual or collective circumstances. Otherwise, it would follow that States could exercise their traditional authority to shift the costs of care among payors representing those better able to bear those costs and those less able to do so. New York has done just that with respect to patients covered by Medicaid: the law simply acknowledges that, given the burdens undertaken by the Medicaid program, the rates charged to that program should be lower than those charged to patients covered by certain other third-party payors.

The same justification exists, however, for charging lower rates to patients covered by Blue Cross. Although the law does not subject Blue Cross patients to the same charges paid by patients covered by commercial insurance—as one official stated, it seeks to "level the playing field"—it establishes that differential for good reason.

Unlike commercial insurers, Blue Cross has long followed a policy of open enrollment, effectively serving as the insurer of last resort for citizens of New York. Unlike commercial insurers, it employs a community-rating system. And, unlike commercial insurers, it makes advance payments to hospitals to assist them in maintaining a secure financial position.[21]

Each of these undertakings—which constitute an important part of the overall health care system in New York—has a negative impact on the financial condition of Blue Cross plans: that is, each of them tilts the "playing field" *against* Blue Cross. In light of that background, however, there is no more cause to prevent New York from granting lower rates to patients of Blue Cross, than to prevent it from granting them to patients covered by Medicaid. As it does for Medicaid patients, or for charitable patients, the State is simply taking account of the need of various classes of patients for hospital services and their respective abilities to pay.[22]

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[21] Blue Cross plans, as non-profit entities, are also subject to a complex regulatory scheme that does not apply to commercial insurers. Thus, for example, Blue Cross premiums, unlike those of commercial insurers, must be approved by the Superintendent of Insurance after public hearings; the Superintendent may refuse such approval if he finds that the premiums, or the premiums derived from a rating formula, are excessive, inadequate, or unfairly discriminatory. N.Y. Ins. Law § 4308. Blue Cross plans also face special regulatory controls on their administrative expenses, reserves, and surpluses. N.Y. Ins. Law §§ 4309(a)-4310. And Article 43 corporations, like Blue Cross, are limited to providing health insurance, while other insurers, not so limited, can enter into other lines of business, from life insurance to car leasing, in order to subsidize their health care coverage. Respondents do not challenge these disparities in treatment which may create incentives *not* to insure with Blue Cross because of higher premium costs.

[22] At times, in fact, the State has linked the amount of the differential to the enrollment policies of the various entities. Beginning in 1990, the State increased by two percent the rates of any Blue Cross plan that did not offer, at a minimum, its basic hospital and medical insurance on a continuous open enrollment basis for the

There is no justification, therefore, for construing ERISA to bar States from setting different rates for different patients. Again, while that might be a possible (if exaggerated) reading of the words "relating to," it would severely limit the authority of States to regulate their health care systems in a rational way. And that reading would not seriously advance any interest in national uniformity, because—whether States regulate rates, or not—the rates charged for health care inevitably reflect a shifting of costs among different patients.[23] Thus, it would deprive States of an important mechanism for im-

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prior 12 months, or that did not continue such open enrollment policy for the 12 months of 1990. 1988 N.Y. Laws, ch. 2, § 11 (codified at N.Y. Pub. Health Law § 2807-c(11)(i)). At the same time, it lowered by two percent the rates of any commercial insurer that offered open enrollment and community rating under certain conditions. 1988 N.Y. Laws, ch. 2, § 11 (codified at N.Y. Pub. Health Law § 2807-c(11)(ii)). In addition, there were other circumstances whereby the failure of a Blue Cross plan to provide open enrollment resulted in a 2% increase in its rate of payment to hospitals. 1988 N.Y. Laws, ch. 2, § 11. These statutory provisions were first extended from 1990 through December 31, 1993 (1990 N.Y. Laws, ch. 922, § 12), but were repealed and replaced by the statute imposing the 11% differential. 1992 N.Y. Laws, ch. 55, § 348.

[23] *See* CBO Papers, *Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift"?*, Cong. Budget Office, May, 1993, at vi ("The contributions of the different sources used to cover unreimbursed costs changed over time. The share of unreimbursed costs offset by private payers increased from 37% in 1980 to 55% in 1989, and the proportion offset by state and local subsidies decreased from 27% in 1980 to 10% in 1989"); *id.* at vi ("Hospitals offset most of the rise in unreimbursed costs during the 1980's by generating higher revenues from private payers, a practice commonly known as 'cost shifting'"); *id.* at 4 ("The practice of cost shifting from the public sector to the private sector does not imply that public-program payment rates are inappropriate or 'too low' or that the costs hospitals incur are 'too high'"); *id.* at 4 ("Evidence of cost shifting indicates that one important way hospitals have responded to public-program controls on spending has been to generate higher revenues from the private sector").

proving the delivery of health care to all citizens, with no obvious benefit to the goals served by ERISA.

C. Congress Has Recognized State Authority To Regulate Hospital Rates.

It is also highly unlikely that Congress, by enacting the general preemption provision in ERISA, meant to preempt the authority of States to regulate health care, including the rates charged for hospital services. Over the past 25 years Congress has frequently recognized, and approved, efforts by States (including New York) to address the problems of restraining health care costs and providing good medical care. During that period, Congress has not only authorized, but has actively encouraged, States to engage in hospital rate-setting activities covering all payors, including ERISA plans and their insurers.

1. Beginning in 1967, Congress has repeatedly addressed the authority of the Secretary of Health and Human Services (and, before that, the Secretary of Health, Education, and Welfare) to waive federal Medicare requirements in order to allow Medicare payments to be set by state reimbursement systems. As shown below, Congress was clearly aware of all-payor reimbursement systems—including differentials among various payors—in granting authority to the Secretary for Medicare to participate in state systems.[24]

This grant of authority to the Secretary originated in a 1967 Medicare Act Amendment, which allowed the Secretary to reimburse hospitals pursuant to an approved demonstration reimbursement system, and to waive federal Medicare and Medicaid reimbursement requirements in order to do so. 42 U.S.C. § 1395b-1. Congress was concerned, however, that the system cover *all*, not just

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[24] As noted above, *see* note 19 *supra*, any "all-payor" system necessarily includes ERISA plans and their insurers because members of plans are significant recipients of in-hospital care.

some, third-party payors. In 1980, therefore, Congress authorized the continuation of such demonstration projects only up to the time that a "*third-party payor reimburses such a hospital on a basis other than under such system.*" Pub. L. No. 96-499, § 903 (codified at 42 U.S.C. § 1395f(b)(3)(A)) (emphasis added). The Conference Committee, which added this limitation, expressly stated that the authority given to the Secretary terminated if "the State's reimbursement system is no longer *applicable to all third-party payors.*" H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 147 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5938 (emphasis added).[25]

In 1982, Congress expanded the Secretary's authority to make Medicare payments "in accordance with a hospital reimbursement control system in a State" if, *inter alia*, the state system encompasses "at least 75 percent" of all in-patient revenues and does not prevent HMOs from negotiating their rates. Pub. L. No. 97-248, Title I, § 101(a)(1) (codified at 42 U.S.C. § 1395ww(c)(1), (c)(1)(A) and (D)). These conditions, once again, necessarily envision state control over the rates of all private insurers and recognize the States' power to preclude negotiated rates for non-HMOs (or even for HMOs, although at the expense of ineligibility for a waiver). Although the Secretary was not compelled to grant a waiver of federal requirements, and thereby acquiesce in state control over hospital rates, the Conference Committee nevertheless stated that it "expect[ed]" the Secretary to do so. H.R. Conf. Rep. No. 760, 97th Cong., 2d Sess. 422 (1982), *reprinted in* 1982 U.S.C.C.A.N. 1202.

The subsequent 1983 amendments to the Medicare Act are also significant, in several related respects. Most im-

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[25] As late as 1990, Congress has subsequently reaffirmed that the "all third party payor" condition in 42 U.S.C. § 1395f(b)(3) continues in force and effect. Pub. L. No. 101-508, § 4008(i)(3), 104 Stat. 1388-51 (amending 42 U.S.C. § 1395f(b)(3)).

portant is the fact that the amendments made mandatory the approval of a state request that Medicare participate in its all-payor system: if the stipulated conditions are met, the Secretary "shall approve" the request. Pub. L. No. 98-21, § 601(c)(3) (codified at 42 U.S.C. § 1395ww (c)(5)(A)). The House Report accompanying the legislation provided: "Your Committee believes that State systems provide a laboratory for innovative methods of controlling health care costs and should, therefore, not be limited to one methodology." H.R. Rep. No. 25, 98th Cong., 1st Sess. (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 365-66. Furthermore, the Committee report stated: "Your Committee believes that State cost containment systems have proven effective in reducing the cost of hospital care and that such systems should be encouraged." H.R. Rep. No. 25, at 147-48, *reprinted in* 1983 U.S.C.C.A.N. 366-67. It then went on to declare that "State systems covering all payors have proven effective in reducing health costs and should be encouraged. Such State programs may be useful models for our national system." *Id.*

At the time of these amendments, Congress specifically reviewed the all-payor systems in New York and other States.[26] *See* H.R. Rep. No. 25, at 147-48, *reprinted in* 1983 U.S.C.C.A.N. 366-67. Then, as now, the New York all-payor system did *not* provide for uniform rates: to the contrary, Blue Cross received a discount of 12%-15% as compared to commercial insurers. N.Y. Pub.

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[26] These 1983 amendments were preceded by Congressional hearings in which officials from New York and other States described their States' all-payor systems and urged the preservation and expansion of the Secretary's Medicare waiver authority. *See Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 98th Cong., 1st Sess. 103 (1983) (Statement of R.M. Crane, N.Y.S. Dep't of Health); *Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. pt. 1, 146-56 (1983) (same).

Health Law § 2808-c(1) and (6).[27] It is thus apparent, first, that Congress has repeatedly endorsed and encouraged state all-payor systems and, second, that Congress has been fully aware that, under all-payor systems, all payors' rates are not the same. Given that background, it is utterly implausible to think that Congress nonetheless intended ERISA to preclude States from establishing different hospital rates for different payors.

2. Evidence of Congressional approval of all-payor systems, including that used in New York, is also found in its approach to the financing of uncompensated care costs. Uncompensated costs may arise in various ways. For example, hospitals incur bad debts when they are unable to collect the uninsured portion of their charges for which patients, including patients insured under ERISA plans, are personally liable. In addition, New York hospitals provide substantial amounts of charity care to the uninsured and under-insured, and, in large measure, are required to do so by federal and state mandates.

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[27] Congressional awareness that all-payor systems did not mean that all payors paid the same rates is established by a 1987 report to Congress by Otis R. Bowen, M.D., then Secretary of Health and Human Services. Otis R. Bowen, M.D., Department of Health and Human Services, *Report to Congress: The Relationship of Medicare PPS to All Payer Systems and Cost-Shifting*, No. 87-1 (Jan. 1987). Among the findings reported by Secretary Bowen to Congress were the following:

> While a hospital may have one set of charges, historically not all payers have paid the same amounts for similar services . . . .
>
> Discounts might be granted for the following reasons:
> — to reflect charge discounts historically received by certain payers (e.g. BC, Medicaid) . . . .
>
> — The fact that payment differentials exist among the payers is well-documented . . . .

Id. at II-47, II-53-54, III-1.

The Medicaid Act requires that rates for hospital services "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." 42 U.S.C. § 1396a (a)(13)(A) (1988). To comply with this requirement, New York includes in the DRG calculation an adjustment reflecting the added costs of uncompensated care. Through a pooling and redistribution system, New York apportions the costs of bad debt and charity care among all payors, except Medicare. N.Y. Pub. Health Law § 2807-c(14). By virtue of a "Special Rule," Congress specifically exempted New York from specific federal requirements applicable to all other States, finding that the New York bad debt/charity care pooling system was deemed to comply with the disproportionate share mandate. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4112(e), 101 Stat. 1330-150 (1987) (codified at 42 U.S.C. § 1396r-4(e)(1)(A)(i) [1988]); H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. 753 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1245, 2313-1499.

This approval, once again, indicates that Congress was aware of, and in full support of, efforts by New York to apportion the costs of hospital care among *all* payors. That being so, it is impossible to imagine that Congress meant, by a general preemption provision in another statute, to declare ERISA plans—and their insurers—*exempt from* laws distributing hospital costs among all payors. It is far more reasonable to think that Congress had no intention at all to shield ERISA plans and their insurers from the obligations borne by other recipients of hospital care, for the simple reason that it would not have thought hospital rates to be within the "field" at which the preemption provision of ERISA was aimed. ERISA plans may prefer to have an exemption, of course, but that is not the same thing as saying that Congress intended for them to have one.

D. The Plans' Option To Benefit From The Lower Blue Cross Rate Is Not A Basis For Preemption.

The court of appeals did not rest its holding of preemption solely on the ground that the New York law affected the costs of ERISA plans: it said, in addition, that the law, by setting lower rates for patients covered by Blue Cross, "purposely interfere[s] with the choices that ERISA plans make for health care coverage." Pet. App. A-22.[28] To some degree, that observation is correct: unlike the lower rates for Medicaid patients, the lower rates for Blue Cross patients might influence consumers (including ERISA plans) to elect Blue Cross coverage.[29] But, for several reasons, this possibility does not justify preemption of the law.

First of all, unless ERISA preempts *all* differences in rates, the theory that it preempts the lower rates for *Blue Cross* patients must turn upon a decidedly odd proposition: that state law providing for lower rates is preempted if—but, apparently, only if—ERISA plans may *benefit* from the lower rates. According to that view, the flaw in the different rates between Blue Cross patients

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[28] State laws, of course, may affect numerous decisions made by ERISA plans. For example, if the court of appeals' reasoning were followed to its logical extent, it would appear that States would be precluded from setting tuition at state universities. Inasmuch as tuition at state universities is lower than tuition at private universities, that disparity might affect the decisions of ERISA scholarship funds (*see* section 3(1) of ERISA, 29 U.S.C. § 1003(1)) about the levels of coverage to be provided.

[29] As noted previously (*see* pages 8-9, *supra*), unlike the state laws at issue in *Alessi*, *Shaw* and *FMC Corp.*, New York law allows ERISA plans to provide whatever benefits they want in whatever manner they want. ERISA plans may decide to self-insure, purchase Blue Cross insurance, purchase commercial insurance, or provide coverage through HMOs. Similarly, some ERISA plans may choose to cover expenses related to certain kinds of medical procedures, whereas others may not. And, some ERISA plans may cover 100 percent of ordinary medical expenses, whereas others may cover any fraction of that amount.

and commercially insured patients is that those paying the higher rates actually have a choice not to do so (by electing coverage from Blue Cross). But it is, frankly, difficult to see why Congress would regard the existence of that choice as an evil to be foreclosed. After all, nothing in the New York law requires ERISA plans to purchase Blue Cross coverage if they prefer other options. The differential simply serves the function of broadening choices for consumers (including ERISA plans) that might otherwise be deterred from selecting Blue Cross coverage because of added costs resulting from its unique obligations.

It might be different, of course, if the choice were not really a choice but a disguised mandate, but no credible argument of that sort can be made here. In the first place, the differential affects only one of many services covered by health care plans. Moreover, it is self-evident that decisions by ERISA plans regarding the most appropriate form of coverage will take account of far more than just the differential. In making that decision, plans would consider a number of other things: the quality of the service offered, the claims processing and sophistication of information systems, as well as the package of benefits offered. J.A. 268, 270-71. To what extent the differential may have an impact upon this choice will also depend upon what in-patient procedures are covered by the insurance, what out-patient procedures are covered, how large and how healthy the risk pool is, what alternative treatment settings are available, and the myriad other factors considered by insurers before determining whether to underwrite and spread a risk. The cost of in-hospital services will be one, but only one, element to be considered.[30]

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[30] We note that HANYS opposed summary judgment on the ground that, insofar as respondents claimed preemption on the basis of a substantial economic impact on plans, there remained a material issue of disputed fact precluding summary judgment. As a practical matter, discovery and (potentially) an evidentiary hearing were necessary to determine what that impact was. For

The law is very different, therefore, from laws struck down by this Court on the ground that they effectively required plans to provide particular kinds of coverage to their members. In *Shaw*, for example, this Court held that two New York laws were preempted by ERISA because, as interpreted and applied, they compelled ERISA plans to provide particular benefits. The Court stated that "the Human Rights Law, which *prohibits* employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which *requires* employers to pay employees specific benefits, clearly 'relate to' benefit plans." 463 U.S. at 97 (emphasis added). Similarly, in *Metropolitan Life*, the Court found that a Massachusetts law "related to" ERISA plans because it compelled them, directly or indirectly, to provide a designated level of mental health benefits. Again, the Court noted that, while the law was "not denominated a benefits-plan law, it bears indirectly but substantially on all insured benefit plans, for it *requires* them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy." 471 U.S. at 739 (emphasis added).

The problem with those laws, however, was just the opposite of the problem asserted by respondents here: that is, the laws left the plans *without* a choice. The laws thus converted decisions properly made by ERISA plans into decisions of the State. Not only does that kind of usurpation put States in a role plainly not contemplated

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example, insured plans pay insurance premiums, not hospital rates. There is no proof in the record of the extent to which any differential over 14 years, or the 13% differential over five years, has been reflected, if at all, in the premiums that respondents charge. Nor have respondents suggested in the record that their premiums would be reduced if the 13% differential were eliminated. The very fact that the Legislature saw a need to add an 11% surcharge shows that the 13% differential did not have the influence on consumer decisions that respondents have repeatedly suggested.

by ERISA (unless it otherwise falls within the savings clause of the Act), but it raises obvious concerns about the ability of ERISA plans to satisfy varying requirements from state to state. By contrast, a law merely providing for greater choice—so long as the choice is real and not a sham—does not offend any of the core interests protected by ERISA.[31]

II. TO THE EXTENT THAT THE NEW YORK LAW PURPOSELY AFFECTS CHOICES ABOUT COVERAGE, IT FALLS WITHIN THE ERISA SAVINGS CLAUSE

Having found that the New York law "purposely interfere[s] with the choices that ERISA plans make for health care coverage," Pet. App. A-22, the court of appeals nonetheless agreed with respondents that it was *not* a law "which regulates insurance" within the meaning of the ERISA savings clause. But respondents cannot have it both ways. If the law "relates to" ERISA plans because it purposely interferes with their decisions about coverage, then it "regulates insurance" and is not preempted. *See* 29 U.S.C. § 1144(b)(2)(A) ("[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").[32]

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[31] To bar States from using economic incentives to encourage consumers (including ERISA plans) to make certain choices would deprive them of an important form of regulation. For example, States may increase in-patient rates to encourage use of ambulatory or out-patient services. Although that disincentive might affect the choices made by members of ERISA plans, so long as ERISA plans are not singled out for special treatment, or their right to elect one form of coverage over another is not precluded, this kind of regulation properly remains within the scope of legitimate state authority.

[32] The relevant part of the district court judgment enjoined the defendants only "from enforcing [the] surcharges against any commercial insurers or HMOs in connection with their coverage of

As we have just discussed, we disagree with the view that a law affecting the costs of an ERISA plan "relates to" that plan within the meaning of Section 514(a), merely because the indirect economic impact of the law may affect choices about insurance coverage. But if that is the case—and laws affecting choices about coverage are thus treated as the functional equivalent of laws mandating particular coverage—then the decision of this Court in *Metropolitan Life* indicates that the savings clause must apply as well. There, the Court held that a law requiring "[a]ny blanket or general policy of insurance . . . or any policy of accident or sickness insurance . . . or any employees' health and welfare fund" to provide certain minimum mental-health-care benefits—while it "related to" ERISA plans—was saved from preemption as a law "which regulates insurance." Declining to read the savings clause narrowly, the Court concluded that "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted." 471 U.S. at 746.

The same reasoning applies here. If there is no difference—for purposes of applying the "relates to" language of Section 514(a)—between laws mandating benefits and laws influencing the choice of benefits, then there is no good reason to distinguish between those laws in applying the savings clause. The Court in *Metropolitan Life* noted that, "while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power *over much of the same regulation.*" 471 U.S. at 739-40 (emphasis added). The court of appeals was thus quite wrong in seeking to construe the savings clause narrowly in order to pre-

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any ERISA plans." Pet. App. A-89 to A-90. Because the district court judgment did not enjoin enforcement of the surcharges against patients of self-insured funds, including self-insured ERISA plans, we do not address whether, with respect to the latter, the "deemer" clause would require preemption of the surcharges. *See generally, FMC Corp.*, 498 U.S. at 60-63 (construing 29 U.S.C. § 1144(b)(2)(B)).

serve the broad scope of preemption. *See* Pet. App. A-28 ("[t]he more expansively the savings clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable"). As the Court pointed out in *Metropolitan Life*, a grudging reading of the savings clause directly conflicts with the governing presumption against preemption of traditional state regulation. 471 U.S. at 741 ("[t]he presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope").[33]

The conclusion that the New York law is "saved" also follows from a straightforward application of the tests used by this Court to determine the scope of the savings clause. In determining whether the savings clause applies to a particular law, the Court first looks to "a common-sense understanding of the phrase 'regulates insurance.'" *Pilot Life*, 481 U.S. at 50. In this regard, the Court has observed that "[a] common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. The Court has thus found that general tort laws or laws generally regulating enforcement of contracts, 481 U.S. at 50, do not regulate insurance. But a law allocating costs within the insurance industry—and "purposely" affecting the rates charged to purchasers of insurance—would seem to fit comfortably within that definition.

The court of appeals, however, took a different view. According to that court, the "common-sense inquiry re-

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[33] That presumption is especially apt with respect to matters involving insurance. This Court has noted—with respect to the McCarran-Ferguson Act (15 U.S.C. § 1011 *et seq.*)—that Congress had the "primary objective of granting the States broad regulatory authority over the business of insurance." *United States Dep't of Treasury v. Fabe*, 113 S. Ct. 2202, 2210 (1993).

veals that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates." Pet. App. A-26 to A-27. But this statement cannot be reconciled with its earlier characterization of the law as purposely directed towards influencing the choices made by ERISA plans (and other consumers) regarding insurance coverage. If that characterization of the law is accepted—as it was for purposes of applying the "relates to" language of the preemption provision—then the law must be regarded as aiming, not just at hospital rates, but at the rates of insurers. That being the case, it does not matter that the law carries out its purpose indirectly by the mechanism of adjusting hospital rates, rather than by more traditional forms of direct regulation. *See Metropolitan Life*, 471 U.S. at 741 (rejecting argument that only "traditional laws" regulating insurance are subject to the savings clause).

The so-called "McCarran-Ferguson Act factors" also support application of the savings clause here. Like a mandated-benefit law, a law seeking to affect insurance choices plainly "regulates the spreading of risk." *Metropolitan Life*, 471 U.S. at 743. Indeed, the court of appeals recognized that the New York law satisfied this factor: it observed that "[b]ecause the 13% and 11% surcharges are designed to encourage ERISA plans—with generally healthier persons—to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs." Pet. App. A-28.

The court of appeals was incorrect, however, in concluding that the other two factors were not satisfied.[34] In *Metropolitan Life*, this Court found that a law "limit-

[34] This Court has not held that each of the three criteria must be satisfied. To the contrary, it has said that "[n]one of these criteria is necessarily determinative in itself" (*United Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)), language suggesting that the failure to meet one of the criteria is consequently not "determinative." In any event, for the reasons stated in the text, we believe that all criteria are satisfied here.

ing the type of insurance that an insurer may sell to the policyholder" satisfied the second factor: that is, it was a law "regulat[ing] an integral part of the relationship between the insurer and the policyholder." 471 U.S. at 743. Again, if there is no material difference under ERISA between laws "limiting" the type of insurance to be sold and laws "affecting" the type of insurance to be purchased, the latter law likewise regulates an integral part of the relationship between insurer and policyholder. In either case, it is the coverage provided to the policyholder that is ultimately at issue.

The court was also mistaken in saying that the New York law does not impose requirements only on insurers. *See* 471 U.S. at 743. If the law is regarded as simply setting hospital rates, that conclusion would be correct. But insofar as the law is regarded as deliberately affecting rates for coverage of hospital costs—the "playing field" for Blue Cross, commercial insurers, self-insured funds, and HMOs—it is, to that extent, imposing requirements upon insurers. And it is that action by the State to which respondents object: that the law interferes with plans' choices *about insurance coverage*.

The application of the law to HMOs does not affect this conclusion. Although HMOs provide health care directly, they bear many of the same risks borne by traditional insurers. Thus, by agreeing to provide care for a predetermined charge, HMOs assume the risk that the need for care will be greater than expected at the time of the agreement with the subscriber. In that respect—the respect in which the New York law is relevant here—HMOs are within the proper scope of persons protected by the savings clause, *i.e.*, those subject to insurance regulation. If the New York law is held to impermissibly affect choices about coverage, therefore, it is nonetheless saved from preemption under the savings clause of the Act.

CONCLUSION

The judgment of the court of appeals should be reversed.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(Caption continued on inside front cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

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61 pp

MARIO M. CUOMO, ET AL.,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (1988 & Supp. IV 1992), preempts portions of New York's comprehensive hospital rate-setting and insurance regulatory scheme, which do not refer to and are not predicated upon the existence of ERISA plans, do not single out ERISA plans for special treatment and do not dictate choices regarding benefits or plan structure, but which may have an indirect economic impact upon such plans?

2. Whether the challenged statutes are saved from preemption as laws regulating insurance within the meaning of ERISA's saving clause?

PARTIES TO THE PROCEEDING

The parties to the proceeding below were: **Petitioners** Mario M. Cuomo, in his official capacity as Governor of the State of New York, Mark Chassin, M.D., in his official capacity as Commissioner of Health for the State of New York, Salvatore R. Curiale, in his official capacity as Superintendent of Insurance of the State of New York, Michael J. Dowling, in his official capacity as Commissioner of Social Services of the State of New York, Robert Abrams, in his official capacity as Attorney General of the State of New York, New York State Conference of Blue Cross & Blue Shield Plans, Empire Blue Cross and Blue Shield, and The Hospital Association of New York State; and **Respondents** The Travelers Insurance Company, Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Aetna Life Insurance Co., Aetna Health Plans of New York, Inc., Mutual of Omaha Insurance Company, Union Labor Life Insurance Company, Professional Insurance Agents of New York, Inc. Trust, New York State Health Maintenance Organization Conference and Health Services Medical Corporation, MVP Health Plan, Wellcare of New York, Mid-Hudson Health Plan, Oxford Health Plan, Capital District Physicians Health Plan, Choicecare Long Island, Independent Health, Travelers of New York, Physicians Health Services, Preferred Care, and U.S. Healthcare.*

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* References to the Appendix to the Petitions for a Writ of Certiorari are referred to as "A- __". References to the Joint Appendix are referred to as "JA- __".

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

Nos. 93-1408, 93-1414, 93-1415

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

The New York State Conference of Blue Cross and Blue Shield Plans (the "Plans")[1] and Empire Blue Cross and Blue Shield ("Empire")[2] respectfully submit this brief requesting this Court to reverse the ruling by the Second Circuit Court of Appeals that ERISA preempts portions of New York Public Health Law § 2807-c (McKinney 1993), which prescribe the rate hospitals must charge particular classes of payors for inpatient hospital services.

OPINIONS BELOW

The January 14, 1994 amended opinion of the Court of Appeals for the Second Circuit is officially reported at 14 F.3d 708 (2d Cir. 1994) and reprinted in its entirety at A-1-34 and JA-30-65.[3] The February 3, 1993 Opinion and Order of

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[1] The Plans are: Empire Blue Cross and Blue Shield; Blue Cross and Blue Shield of Utica-Watertown, Inc.; Blue Cross and Blue Shield of Central New York, Inc.; Finger Lakes Health Insurance Co., Inc.; Finger Lakes Medical Insurance Co., Inc. (dba Blue Cross and Blue Shield of the Rochester Area); and Blue Cross and Blue Shield of Western New York, Inc. (JA-215.)

[2] Each of the Plans, including Empire, is a not-for-profit corporation operating in accordance with Article 43 of the New York State Insurance Law. As such, they do not have parent companies, subsidiaries or affiliates of the type subject to Rule 29.1.

[3] The original opinion of the Second Circuit Court of Appeals, dated October 25, 1993, is unofficially reported at 62 U.S.L.W. 2290 (2d Cir. Oct. 25, 1993). (A-35-62.) The original opinion and the amended opinion (issued after the Second Circuit granted rehearing) are identical except for the discussion of preemption under the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.* (1988 & Supp. IV 1992). The issue of FEHBA preemption is not before this Court.

the United States District Court for the Southern District of New York is officially reported at 813 F. Supp. 996 (S.D.N.Y. 1993) and reprinted in its entirety at A-63-90.

JURISDICTION

The petition for a writ of certiorari was filed on March 9, 1994 and was granted on October 7, 1994. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The relevant provisions of ERISA's preemption provision, 29 U.S.C. § 1144(a) (1988), are reprinted at A-99-100. The relevant provisions of N.Y. Pub. Health Law § 2807-c (McKinney 1993) are reprinted at A-101-113.

STATEMENT OF THE CASE

For over ten years, New York State has regulated hospital rates in a manner that not only controls costs but also uses that control to effectuate specific insurance objectives. The difference between what the Plans pay for inpatient hospital care and what plaintiffs pay—the "differential"—assists the Plans in shouldering the burden of open enrollment for individuals and small groups (that is insuring all applicants without regard to age, occupation or physical condition) on a community rated basis as well as other publicly responsible activities. The differential was enacted into statute in 1983, but codified a decades old difference in the hospital rates paid by the Plans as compared to other payors. (JA-161-62, 179-82, 218-23.)

The differentials apply generally to categories of payors for hospital services without regard to whether the payor's customer is an ERISA plan. They do not refer to or operate with

regard to the existence of ERISA plans. Nor do they dictate or restrict the choices plans can make regarding benefits to be provided or their administration. At most, they may indirectly impact the cost to an ERISA plan—like countless other state laws—of purchasing hospital benefits for its participants and beneficiaries.

In ruling that ERISA preempts portions of New York's Public Health Law, the Second Circuit has distended ERISA preemption to insulate ERISA plans from state laws designed to promote widespread access to affordable health insurance by controlling hospital costs simply because those laws may indirectly impact the cost to an ERISA plan of purchasing benefits. The Second Circuit's determination not only cripples New York State's efforts to grapple with the cost and financing of hospital services and the availability of health insurance, but also guts other state legislative reform efforts in this arena. As Judge Freeh acknowledged:

> Defendants correctly note that, to the extent that the Court finds that New York's statutes "relate to" employee benefits plans, then "ERISA preempts all state hospital rate-setting statutes, at least to the extent they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." This result is obviously undesirable in that it greatly complicates states' efforts to regulate and control hospital costs.

Travelers Ins. Co. v. Cuomo, 813 F. Supp. 996, 1006 (S.D.N.Y. 1993). (A-77-78.)

In fact, as predicted by Judge Freeh, New York's healthcare system and insurance reform efforts have already begun to unravel. Relying exclusively upon *Travelers*, *New York State Health Maintenance Organization Conference v. Curiale*, No. 93-1298 (S.D.N.Y. Feb. 25, 1993), struck down an integral portion of New York's landmark health insurance reform. The plaintiffs in *Connecticut General Life Ins. Co. v. Cuomo*, No.

93-3648 (S.D.N.Y. filed May 27, 1993), have challenged New York's use of diagnosis related groups ("DRGs") in setting reimbursement rates on ERISA preemption grounds. And in *Capo v. HANYS*, No. 93-7996 (S.D.N.Y. filed Dec. 21, 1993), the plaintiffs filed a class action on behalf of all employee benefit plans seeking return of the over $1.5 billion attributable to payment of the 13% differential since 1988. Moreover, if the Second Circuit is correct, not only will state efforts to regulate in the healthcare arena be upset, but states will also be precluded from enacting any legislation that may have an effect on the costs to ERISA plans of purchasing goods or services.

A. Blue Cross and Blue Shield Plans in New York

The Plans comprise an unincorporated association consisting of all Blue Cross and Blue Shield Plans operating in New York State. Each is a not-for-profit health services corporation organized and existing pursuant to Article 43 of the New York Insurance Law. During 1991, Empire afforded health coverage to more than eight million persons located primarily throughout the twenty-eight counties that comprise the New York City Metropolitan, Mid-Hudson, and Northeastern areas of New York State and reimbursed hospitals $2.5 billion for inpatient hospital services rendered to persons Empire covered. The remaining Plans provided coverage to more than four million other persons throughout the rest of the State. (JA-194, 215.) The majority of the twelve million persons covered by the Plans are participants or beneficiaries of employee benefit plans governed by ERISA.

Decades ago, the Plans were incorporated with the mission to undertake efforts to issue insurance to as many people and groups as financially practical. For example, Empire's statement of corporate purpose calls for Empire to provide "the best possible coverage for the largest possible portion of the self-sustaining population on the most cost-effective basis." (JA-197.) In furtherance of this mission, the Plans sell cover-

age, including individual and Medicare supplementary coverage, on an open enrollment basis, *i.e.*, to any person without discriminating on the basis of prior illness, physical condition, age, occupation or sex. The Plans have traditionally provided this coverage at a uniform community-wide rate otherwise unavailable for high-risk individuals. (JA-198-203.) As the Second Circuit noted, "[a]s the insurer of last resort, the Blues insure persons or groups that are, on a whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers." (JA-58.)

The Plans' coverage of individuals and provision of Medicare supplemental coverage for the elderly sets them apart from commercial insurers. In almost all cases, the Plans operate at a loss with respect to the coverage of these persons. (JA-201.) By contrast, most commercial insurers do not even offer health insurance to individuals and only a few provide Medicare supplemental insurance coverage to New York's elderly.[4] (JA-201-02.)

The Plans' underwriting practices, endorsed by the New York Legislature, have greatly increased the number of insured persons in New York State with the obvious and beneficial effect of spreading costs to as many insureds as possible. In fact, New York has 20.8% fewer uninsured persons than the national average.[5] (JA-203.)

Furthermore, at any point in time, the Plans have outstanding more than $300 million in working capital advances to their member hospitals. These interest-free working funds represent a significant cost savings to hospitals. (JA-203-04.)

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[4] Even today, most of the insurance company plaintiffs in this action, such as the Travelers Insurance Company and Aetna Life Insurance Co., do not offer these coverages. (JA-202.)

[5] There is a correlation between the number of uninsured persons and whether health insurance is available on an open enrollment basis in other states. The eleven states where insurers offer open enrollment have 20% to 30% fewer uninsureds than the national average. (JA-202-03.)

The Plans have also historically engaged in a variety of other public policy initiatives including, most recently, a program to provide healthcare coverage to uninsured children in New York. (JA-204.)

B. New York State's Current Hospital Rate-Setting Scheme

New York State has adopted a comprehensive statutory scheme that regulates the insurance marketplace by controlling inpatient hospital rates. (JA-150.) To this end, the New York Legislature divided the various payors for hospital services into three categories, two of which are affected by the hospital differentials at issue here. The first consists of state government (Medicaid), Article 43 corporations such as each of the Plans (including Empire) and HMOs. *See* N.Y. Pub. Health Law § 2807-c(1)(a) (McKinney 1993). (A-101.) The second category consists of self-insured funds that pay hospitals directly, commercial insurers licensed in New York whose coverage is based on all hospital services rendered, volunteer firefighters, volunteer ambulance companies and no-fault auto insurers. *See* N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993). (A-102-03.) A third includes "all others." Payors falling within the "all others" category include "self-pay" patients, patients covered by self-insured groups that do not make direct payments to hospitals and patients covered by commercial insurance policies that do not pay on an expense incurred basis. N.Y. Pub. Health Law § 2807-c(1)(c) (McKinney 1993). (A-103.)

Hospitals must charge the first two categories of payors strictly regulated rates based upon the DRG into which a patient falls. *See* N.Y. Pub. Health Law §§ 2807-c(1)(a)-(b) (McKinney 1993). (A-101-03.) The DRG rate is set by the State Department of Health and is based upon the cost of treating an average patient with a particular primary diagnosis. However, the rate is adjusted for each particular hospital to take into account operating costs, capital costs,

malpractice insurance, bad debt and charity care costs, primary health service program costs and physicians' excess malpractice insurance. Thus, the rate for a particular DRG will necessarily vary from hospital to hospital. And the actual cost of treating a particular patient may be more or less than the DRG to which that person is assigned. (JA-184-87, 152-53, 249-57.) Payors falling within the "all others" category pay actual hospital charges which are subject to a statutory limit. (JA-188, 154.) As such, the hospital differentials at issue need not necessarily affect any payor which falls into the class of "all others."

New York has determined that its Medicaid program, publicly financed and providing care for the poorest New Yorkers, should be in the first category of payors. To help compensate them for the burden of their community rating, open enrollment and other publicly responsible activities, HMOs[6] and Article 43 corporations such as the Plans are also in the first category. *See* N.Y. Pub. Health Law § 2807-c(1)(a). (A-101; JA-188, 153, 165-66.) Indeed, plaintiffs have acknowledged that the Plans were "granted the 13% to pay for the cost of open enrollment and community rating." (JA-207; Record; Affidavit of Jerry Weissman, sworn to September 30, 1992 ("Weissman Aff.") Exh. H.) Thus, whereas hospitals bill Article 43 corporations at the DRG rate, payors in the second category, including commercial insurers and self-insured funds that pay hospitals directly, must pay the DRG rate plus the 13% "differential." *See* N.Y. Pub. Health Law § 2807-c(1)(b). (A-102-03.)

Beginning in the late 1980s, the insurance goals promoted by the hospital cost control statute were jeopardized as a result of the commercial insurers' selection of the best risks

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[6] In addition to receiving the benefit of the differential, HMOs are permitted to negotiate their payments to hospitals. N.Y. Pub. Health Law § 2807-c(2)(b)(i) (McKinney 1993). Negotiated rates have not been challenged on the basis of ERISA preemption even though they may result in more favorable treatment for HMOs.

from the Plans' community rated pools. The experience of such pools increasingly deteriorated and the community rate required to serve the relatively poorer risks that remained increased as a result. (JA-204-06, 232-33, 164-66.) Effective April 2, 1992, Section 348 of the Omnibus Revenue Act of 1992 amended N.Y. Pub. Health Law § 2807-c to require hospitals to bill commercial insurance companies subject to the DRG rate an additional 11%. 1992 N.Y. Laws, ch. 55, § 348. (A-104.) Hospitals paid the 11% differential into the State's general revenue fund. (A-105.)

The additional differential was designed to offset the competitive advantage that commercial insurers had garnered by carefully selecting the persons they would insure and by excluding persons who were ill or worked in industries which made them more likely to need healthcare services. (JA-164, 200-01, 204, 293-94.) By increasing commercial insurers' payments to hospitals, the legislature intended the 11% differential to compensate in part for the effects of risk selection by alleviating some of the significant risk differences (*i.e.*, claims costs) between the Plans and commercial insurers.[7] The resulting risk-spreading was designed to help the Plans offer affordable insurance to a broader section of the population. (JA-216-38, 164, 154-55; Record; Affidavit of Albert F. Antonini, sworn to September 25, 1992 ("Antonini Aff.") Exhs. I, N-S.) As enacted, the 11% differential was only in effect for one year. It terminated on March 31, 1993 when New York's insurance reform legislation for individuals and small groups became effective.[8]

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[7] The Plans' loss of good risks to commercial insurers has virtually obliterated their community pools. In 1986, for example, Empire had a good risk to bad risk ratio of ten to one in its community pools, but by 1992, at the commencement of this action, this ratio had fallen to three to one. (JA-205.)

[8] As of April 1, 1993, new legislation went into effect requiring all insurers offering health insurance in New York to individuals and small groups to do so on a community rated and open enrollment basis. N.Y. Ins. Law § 3231 (McKinney Supp. 1994). Adjustments to rates for

Section 346 of the Omnibus Revenue Act of 1992 subjects HMOs, including those operated by the Plans, to a differential of up to 9% if they fail to enroll a targeted number of Medicaid patients.[9] N.Y. Pub. Health Law §§ 2807-c(2)(a)-(e) (McKinney 1993). (A-106-13; JA-208-09, 155, 175-77; Record; Antonini Aff. Exh. P.) Section 346 requires HMOs to pay the applicable differential into a statewide pool established by the Commissioner of Social Services of the State of New York, who then deposits this money into New York State's general revenue fund. (JA-155, 175.)

C. Legislative History of the Differentials

Unlike the legislative history of ERISA, which the Second Circuit found to be a "veritable Sargasso Sea of obfuscation," (JA-48), the history and purpose of the inpatient differential in New York is made clear by twenty-five years of legislatively authorized studies and analyses, with which the Record is replete.

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such insureds based on age, sex, health status or occupation are no longer permitted. In subsequent hospital reimbursement legislation, 1993 N.Y. Laws, ch. 731, § 35, the New York legislature retained the 13% differential, recognizing that the new legislation has not redressed all the inequities in the insurance market. First, the open enrollment and community rating legislation has not mandated that commercial insurers provide coverage in the individual market. Since commercial insurers for the most part declined to provide such coverage, the Plans continue to provide coverage to the vast majority of individual insureds in New York State. Coverage to individuals, who as a group incur significantly higher claims experience than insureds in group coverage, continues to cause the Plans significant losses. (JA-201.) Second, it will take a number of years for the new community rating legislation to balance out the risks in the individual and small group pools due to the saturation of the Plans' community rated pools with New York's highest risks. (JA-294.) Third, the Plans have continued costly public interest undertakings that commercial insurers have never undertaken such as providing over $300 million of non-interest bearing advances to hospitals. (JA-203-04.)

[9] Pursuant to recent legislation, the 9% differential was amended and extended from December 31, 1993 to December 31, 1995. 1993 N.Y Laws, ch. 731, § 35.

Over the quarter century prior to the enactment of the first statutory differential in 1983, the Plans obtained discounts or negotiated agreed-upon reimbursement rates instead of paying the hospitals' charges. The Plans generally obtained a substantial discount from the hospitals in exchange for prompt payment, cash advances and the commitment to provide coverage to individuals and groups unable to obtain insurance anywhere else in New York. (JA-218-19, 161-62.) This system benefitted both hospitals and New Yorkers by reducing the number of uninsureds in New York and providing sufficient income to hospitals. The system also benefitted the Plans by enabling them to compete with for-profit commercial insurers who failed to provide these community services. Such a policy was necessary as "Blue Cross has limitations imposed by the competitive environment in which it finds itself." (JA-219.) The market balanced these limitations by requiring commercial insurers to pay more for inpatient hospital care.

In 1965, the Governor's Committee on Hospital Costs reported on efforts to restrain costs of hospital care and to improve the quality of healthcare services. The Committee urged the Plans to continue unrestricted enrollment and other public activities. Underscoring the necessity for a differential, it noted that a system that "gravitates toward serving favorable risks, and leaves unreigned the excess cost to high users, is not meeting this social need." (JA-220-21.)

In 1969, in response to the rising costs of hospital care, New York State enacted the Hospital Cost Control Law, 1969 N.Y. Laws, ch. 957, § 2, which for the first time regulated the rates charged by the hospitals to Medicaid and the Plans.[10] (JA-180.) Commercial insurers' payments and other payors' payments were not regulated. The difference between the

[10] Medicare rates were already regulated by the federal government by this time. In 1976, upon adoption of New York's HMO Act, Article 44 of the Public Health Law, HMOs were brought under the State's Hospital Cost Control Laws. 1976 N.Y. Laws, ch. 938, § 4.

regulated Blue Cross rates and the rates for other payors was "the differential," which ranged between 25% and 40%. (JA-222, 162.)

As hospital costs continued to rise through the 1970s, the State recognized that an effective hospital cost control system would have to regulate revenues from all payors. (JA-180-82.) The Legislature established the Council on Health Care Financing to address this issue. In 1980, after evaluating the hospital reimbursement law, the Council recommended formal legislative adoption of the differential in rates into statute, recognizing that "a prime consideration in establishing a payment differential is to reflect economic advantages or disadvantages and social considerations granted by differing operational policies and practices [of insurers] . . . on the people of New York State." (JA-223.)

In 1983, the Legislature codified the differential at a lower rate than previously used in the marketplace in a comprehensive all-payor reimbursement system known as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). The statutory differential was then studied by the State Hospital Review and Planning Council which issued its first report in 1985. (JA-223-24, 163.) The Council noted:

> [D]ifferentials . . . should continue to be appropriate means to enable the State to achieve certain social policy objectives, including providing hospitals with certain levels of working capital and encouraging the availability of substantial and affordable health insurance.

The Council also reiterated the historical bases for the differential: (1) prepayment to hospitals, which provides working capital and costs savings to hospitals; and (2) social policy factors such as coverage practices which make insurance available and affordable and which provide indirect financial support to hospitals by averting bad debts. (Record; Antonini Aff. Exh. E.) The Charge Differential Analysis Committee of the New York State Hospital Review and Planning Council likewise

noted in 1989 that the differentials were premised on these two key factors.[11] (Record; Antonini Aff. Exh. K.)

In 1989, the State Hospital Review and Planning Council and the Subcommittee on Insurance of the New York State Legislature's Council on Health Care Financing issued reports on the differentials. Their reports found that the differential was the Legislature's leverage for "encouraging payors and hospital providers to engage in activities which accomplish public policy objectives," (JA-229), and was a "useful vehicle to promote social policy objectives." (JA-230.) Relying upon these reports, the Legislature maintained the 13% differential in 1990 NYPHRM legislation, as well as in the present NYPHRM effective January 1, 1994.

D. Decisions of the Courts Below

By this action, plaintiffs challenged the 13%, 11% and 9% differentials as preempted by ERISA.[12] Plaintiffs moved for summary judgment requesting that the district court invalidate the differentials. The New York State defendants and intervenors—the Plans, Empire and the Hospital Association of New York State ("HANYS")—cross-moved for summary judgment dismissing the complaints. By Opinion and Order dated February 3, 1993, the Honorable Louis J. Freeh held that ERISA preempted the challenged hospital differentials as

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[11] The Council also noted that the Plans alone open enrolled all individuals without medical underwriting and subsidized insurance coverage for vulnerable groups such as the elderly. They did all this at community rates available solely because they were able to obtain sufficient numbers of healthy, low risk subscribers to subsidize the high risk claims. Significantly, the Council recommended that commercial insurers should be granted the statutory differential if they choose to fulfill these policy objectives. (Record; Antonini Aff. Exh. E.)

[12] Plaintiffs also challenged the 13% and 11% differentials on the grounds that they are preempted by FEHBA and an actuarial letter issued by the New York State Department of Insurance to regulate the issuance of stop-loss insurance contracts to self-insured plans on the grounds that it is preempted by ERISA. Neither of these issues is before this Court.

to commercial insurers and HMOs. (A-68-82.) The district court also rejected the argument that the 13% and 11% differentials fall within the scope of ERISA's "saving clause" and are, therefore, saved from preemption. (A-78-82.) By Opinion and Order dated February 9, 1993, the district court granted a stay of its Order insofar as it concerned the 13% differential.[13] (A-93-98.) The Second Circuit Court of Appeals affirmed the district court's decision that the 13%, 11% and 9% hospital differentials are preempted by ERISA and affirmed the district court's conclusion that the 13% and 11% differentials do not regulate insurance within the meaning of ERISA's saving clause. (JA-30-65.)

SUMMARY OF THE ARGUMENT

The Second Circuit erred in ruling that the challenged differentials "relate to" ERISA plans. In so concluding, the Second Circuit embraced an overly expansive view of ERISA preemption that finds no support in the prior decisions of this Court. Nor does ERISA's legislative history evidence congressional intent to preempt laws enacted within the states' police powers that were designed to control hospital costs and increase access to affordable health insurance.

Here, the challenged statutes apply generally to payors for hospital services without regard to the existence of ERISA

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[13] The district court denied a stay as to the 11% and 9% differentials except that it required plaintiffs to escrow the amounts attributable to these differentials in interest bearing accounts. (A-98.) To date, the deposits remain in the escrow accounts.

In any event, Congress amended the Internal Revenue Code to provide that employers will lose certain tax deductions relating to costs of providing health care coverage to plan participants if their plans do not pay the New York hospital differentials. The effective date of the amendment was the day before the district court's decision in this action. The amendment will expire on May 12, 1995. *See* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13442, 107 Stat. 568, *reprinted in* 1993 U.S.C.C.A.N. (amending 26 U.S.C. § 162(n)).

plans. Many ERISA plans obtain coverage through the Plans, which benefit from the differentials; other ERISA plans obtain coverage through commercial insurers or self-funded plans, which pay the differentials. The challenged statutes, furthermore, do not dictate or restrict the choices that an ERISA plan can make regarding particular benefits provided or the manner in which such benefits are administered. At most, the challenged statutes may increase the cost of purchasing hospital services from particular insurers. However, this increase in cost does not amount to discrimination against or impermissible interference with an ERISA plan. The disparities in costs created by the differentials are no different than the disparities in costs created by numerous state laws as well as the commercial realities of doing business.

This Court should embrace the reasoning of the Third Circuit Court of Appeals in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), to uphold the challenged statutes. *United Wire* involved a challenge, almost identical to that presented here, to New Jersey's hospital rate-setting scheme. Upholding New Jersey's scheme against an ERISA preemption challenge, the Third Circuit rejected the argument that the economic impact of the challenged statutes justified a finding of preemption. Rather, the increase in costs was no different from any state regulation that increases the costs of goods and services that hospitals consume and include in the prices charged for services. *Id.* at 1193. *United Wire* further reiterated that Congress did not intend to foreclose regulation enacted under the states' police powers. *Id.* at 1196. In sum, like the differentials here, the challenged components of New Jersey's hospital rate-setting scheme were generally applicable laws which did not dictate or restrict the choices ERISA plans made in purchasing benefits and, accordingly, were not preempted. *Id.* at 1195.

In any event, the 13% and 11% differentials are saved from preemption as laws regulating insurance. Contrary to the

Second Circuit's conclusion, the differentials regulate insurance as a matter of c. mmon sense. The differentials play a dual role in both controlling hospital costs and in regulating insurance. In fact, the New York Legislature has clearly articulated that the purpose of the differentials is to affect the health insurance market in order to increase the availability of coverage and to promote practices viewed as publicly responsible by the Legislature.

In considering whether the challenged statutes are saved from preemption, the Second Circuit also erred in rigidly applying the three factors used to interpret the meaning of "business of insurance" under the McCarran-Ferguson Act. By way of contrast, ERISA's saving clause broadly applies to "any person" subject to insurance regulation—not just to core activities constituting the "business of insurance." Thus, while the McCarran-Ferguson Act criteria are instructive, none of the criteria should be viewed as determinative. Indeed, in *United States Department of the Treasury v. Fabe*, 113 S. Ct. 2202 (1993), this Court moved away from rigid application of the McCarran-Ferguson Act criteria.

Nonetheless, particularly in light of the discrete phraseology of ERISA's saving clause, the challenged statutes meet all three of the McCarran-Ferguson Act criteria. First, as found by the Second Circuit, the differentials spread risk by creating an incentive for good risks to participate in the same insurance programs as poor risks, thus spreading the costs of persons who are ill over a larger portion of the population. Second, the differentials are integral to the relationship between the insurer and the insured. The differentials have an impact on whether coverage is available and the cost of that coverage—factors which are at the core of the relationship between the insurer and the insured. Third, the differentials are key to New York's insurance industry and are directed at that industry.

Finally, the Second Circuit erred in finding that HMOs are not insurers "as a matter of law." To find that HMOs are not

insurers would ignore the monumental changes which have occurred in the health insurance marketplace and ignore that the function of HMOs is to accept the risk of providing health services for a premium payment in the same fashion as insurers. The distinction between traditional insurers and HMOs is becoming increasingly blurred as each adopts products and practices used by the other. Moreover, the New York Legislature has taken pains to specify that HMOs have only a "limited exemption" from particular insurance statutes and has explicitly subjected HMOs to most of the same regulations as insurance companies and, therefore, HMOs are "person[s]" subject to insurance regulation under ERISA's saving clause.

ARGUMENT

I.

NEW YORK STATE'S HOSPITAL RATE-SETTING AND INSURANCE REGULATORY SCHEME DOES NOT "RELATE TO" ERISA PLANS

A. Prior Decisions of this Court Do Not Support the Second Circuit's Finding that the Challenged Differentials "Relate to" ERISA Plans

Ruling that the challenged differentials "relate to" ERISA plans,[14] the Second Circuit erroneously expanded ERISA's preemption provision to insulate ERISA plans from an otherwise valid exercise of the State's police powers. In effect, the Second Circuit ruled that New York may not promote access for all New Yorkers to affordable health insurance by controlling hospital costs simply because such laws may have an indirect economic effect upon ERISA plans. The Second Circuit held that although the challenged statutes "do not refer to

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[14] 29 U.S.C. § 1144(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA.

ERISA plans," they nonetheless "relate to" ERISA plans within the meaning of ERISA's preemption clause because they "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand* [*Co. v. McClendon*, 498 U.S. 133 (1990)]." *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 719 (2d Cir. 1993). (JA-52.) Broadly construing and relying heavily upon *Ingersoll-Rand*, the Second Circuit found that the challenged statutes had a "connection with" ERISA plans because they increase the costs of providing hospital coverage through commercial insurers, self-funded plans and HMOs. This indirect economic impact, in turn, impermissibly impacts on plan structure and administration. *Id.* at 721. (JA-54-55.)

The Second Circuit's expansion of ERISA preemption to include generally applicable state laws designed to control hospital costs and to regulate insurance is neither consistent with the reasoning of this Court's prior decisions nor supported by ERISA's legislative history. First, this Court's decision in *Ingersoll-Rand* does not support the Second Circuit's expansive view of preemption. *Ingersoll-Rand* involved an employee's claim that he was wrongfully discharged to avoid payment of pension benefits under an ERISA plan. *Ingersoll-Rand*, 498 U.S. at 135. Finding the wrongful discharge claim preempted, this Court reasoned: "We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Id.* at 139. To the contrary, "[t]he Texas cause of action *makes specific reference to*, and indeed is premised on, the existence of a pension plan. . . . Because the court's inquiry must be directed to the plan, this judicially created cause of action 'relates to' an ERISA plan." *Id.* at 140 (emphasis added).

Ingersoll-Rand neither adopted nor applied the "less stringent connection with standard" referred to by the Second Circuit. Nor has any other decision of this Court embraced such a standard. And *Ingersoll-Rand* did not even raise the issue of whether indirect economic impact upon an ERISA plan is sufficient to preempt.

Second, this Court has never found a generally applicable state statute that prescribes the amounts hospitals must charge preempted simply because that law may have an indirect and solely economic impact on ERISA plans, just like the impact on any other plans. Rather, this Court has found that a state law "relates to" employee benefit plans where the law singles out ERISA plans for special treatment,[15] where the rights or restrictions the law creates are predicated on the existence of ERISA plans,[16] where the law requires plans to provide specific benefits or dictates choices regarding plan structure, administration or reporting[17] or where the law provides an

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[15] *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (finding that Georgia garnishment statute that singled out ERISA plans for special treatment was preempted).

[16] *See District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580 (1992) (ruling that ERISA preempts a District of Columbia statute requiring employers who provide health insurance for employees to provide equivalent coverage for injured employees eligible for workers' compensation); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (holding that ERISA preempts employee's claim that he was wrongfully discharged because his employer sought to avoid making contributions to his pension fund).

[17] *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (finding that ERISA preempts a Pennsylvania antisubrogation statute which prevented Pennsylvania plans "from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (stating that Massachusetts statute requiring the provision of certain minimum mental health benefits "relates to" employee benefit plans); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (concluding that New York's Human Rights Law which prohibits employers from structuring their plans in a manner which discriminates on the basis of pregnancy and the Disability Benefits Law which requires the payment of specified benefits "relate to" ERISA plans); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (ruling that ERISA preempts New Jersey statute to the extent that it prevents ERISA plans from decreasing benefits by the amount of a workers compensation award).

alternative cause of action to employees to collect benefits protected by ERISA.[18]

This Court should draw a line between the type of laws found preempted by its prior decisions and the statutes here at issue. As the Second Circuit recognized, the challenged statutes do not refer to ERISA plans. (JA-52.) Nor are they predicated upon the existence of ERISA plans. Rather, the challenged differentials are ERISA neutral. They do not apply solely to ERISA plans and do not single out ERISA plans for special treatment. Many persons insured by the Plans are members of ERISA employee benefit plans; some are not. Nevertheless, in all cases the Plans obtain the benefit of the differentials. (JA-195-96.) Correspondingly, many persons covered by commercial insurance and self-insured groups are members of ERISA plans; many are not. Yet commercial insurers and self-insured funds never obtain the benefit of the differentials. New York's hospital rate-setting scheme applies generally to fees charged by hospitals to many classes of payors, including Article 43 corporations, commercial insurers and self-insured groups. The hospital charge is determined strictly by reference to the category of payor and not by whether or not an ERISA employee benefit plan happens to be the insured or whether the hospital patient is a participant or beneficiary of an ERISA plan.

The challenged statutes, furthermore, do not encroach upon Congress' efforts to ensure that state laws do not require ERISA plans to provide particular benefits or to structure or administer their plans in a particular fashion. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9, 11 (1987). New York State's hospital reimbursement scheme neither prescribes a particular method for calculating benefits nor requires that particular benefits be paid or that they be paid at a particular

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[18] *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (explaining that state law claim which essentially seeks benefits denied is preempted by ERISA).

level. The differentials merely impact the amount an ERISA plan must pay for hospital services. However, differences in cost will persist hospital to hospital and state to state—with or without New York's legislative plan. This ought not be deemed to unduly interfere with national uniformity of plan administration or create the type of patch-work scheme feared by Congress.

Nor does the economic impact of the hospital differentials impermissibly interfere with the choices ERISA plans make for coverage. ERISA plans must pay for the benefits they provide to their participants and beneficiaries, and countless state laws, as well as the commercial realities of doing business in a particular area, will affect the cost of providing coverage. For example, New York has implemented regulations limiting the hours interns and residents can work and requiring experienced physicians to supervise training. The State has further required that hospital rates be increased to reflect the additional cost of State mandated staffing requirements and these increased rates affect the amounts paid by ERISA plans for hospital services. (JA-186.) Indeed, ERISA plans must take dozens of cost and non-cost factors into account when they determine which benefits to provide and how to structure their plans. And whether the cost is fixed by state laws or determined by the economic realities of a free market, all costs may influence choice of coverage. However, the amount paid for hospital care, like the amount paid for many other services, does not dictate or restrict the structure, administration or type of benefits provided by a plan. Paying for hospital care is simply one of the many costs of doing business. As with any other cost of doing business, the payor must merely pay the amount billed by the hospital.

Indeed, Congress could not have intended that ERISA plans would pay a uniform rate for a particular hospital service throughout the United States. Nor could Congress have intended that hospital charges would be calculated by a uniform methodology. In fact, no two hospitals in New York

State have the same reimbursement rate for a particular service. If two persons underwent the same surgical procedure in different hospitals in New York State, they would be billed different amounts under the DRG system, regardless of whether they were participants in an ERISA plan. And, in the absence of hospital cost control legislation, there would still be no uniformity in the amounts charged by New York State hospitals. (JA-191-92, 256-57.) Furthermore, hospital charges vary from state to state and region to region. Each state, in turn, has its own particular method for hospital payment. (JA-256.) However, such differences in costs of providing benefits do not interfere with national uniformity of plan structure and do not amount to impermissible interference with or discrimination against choices ERISA plans make in purchasing benefits.

This Court has recognized the distinction between laws that dictate choice regarding the benefits and administration of ERISA plans and those that may have only an indirect economic impact upon plans. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 831 (1988), determined that ERISA did not preempt Georgia's general garnishment statute even though compliance with a garnishment order would impose additional administrative burdens and costs on plans. Reaching this conclusion, *Mackey* reasoned "that money judgments against ERISA welfare benefit plans . . . must be collectible in some way; garnishment is one permissible method." *Id.* at 834. Indeed, it would stretch ERISA's preemption clause beyond anything contemplated by Congress to find that ERISA plans can be excused from complying with state statutes that prescribe the amounts hospitals must bill simply because the law may indirectly affect their cost of purchasing benefits.[19] If that were the case, then all state regu-

[19] The irrational ramifications of the Second Circuit's determination can already be seen in the numerous cases challenging hospital and insurance regulations on ERISA preemption grounds. For example, the Second Circuit struck down an assessment on hospital revenues in *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir.

lations that affect the cost of purchasing goods and services used by ERISA plans would be preempted. However, ERISA plans, like any other benefit plan, must pay for hospital services, and New York State's hospital rate-setting and insurance regulatory scheme is one permissible method for determining the level of that payment.

Correctly interpreting this Court's prior decisions, the Third Circuit in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), recognized that laws that merely have an indirect and solely economic impact upon ERISA plans do not have a sufficient connection with ERISA plans to be preempted. In *United Wire*, the Third Circuit upheld New Jersey's hospital rate reimbursement law against an ERISA preemption challenge. Like New York's hospital rate-setting and insurance regulatory scheme, New Jersey had adopted legislation to "contain the rising costs of healthcare services, and to ensure the financial solvency of hospitals." *Id.* at 1189. Under New Jersey's hospital rate-setting system the basic rate was the DRG rate. However, the hospital bill had other components which the plaintiffs claimed were preempted by ERISA, such as a 2.2% discount granted to high volume payors and an 11% discount granted to payors with open-enrollment policies. *Id.* at 1189-90. Thus, like the plaintiffs in this action, the *United Wire* plaintiffs challenged the

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1994). Even further expanding upon the broad approach taken to ERISA preemption in *Travelers*, the Second Circuit in *NYSA-ILA* stated: "[T]he HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them." *Id.* at 827. Thus, *NYSA-ILA* can be read as stating that any law which impacts the cost of health care services is subject to preemption. Indeed, shortly after the Second Circuit rendered its decision in *NYSA-ILA*, plaintiffs in *Trustees of and the Pension, Hospitalization Benefit Plan of the Electrical Industry v. Cuomo*, No. 92-5589 (E.D.N.Y. filed Nov. 25, 1992) (an action challenging the 13% differential and New York's bad debt and charity care surcharge on ERISA preemption grounds) filed a brief with the court urging such a reading. *See supra* pp. 4-5.

"differentials" in the hospital rate charged to particular classes of payors.[20]

United Wire recognized that New Jersey's hospital reimbursement scheme does not refer to ERISA plans. *United Wire*, 995 F.2d at 1192. In contrast with *Travelers*, however, *United Wire* reasoned that:

> New Jersey's scheme may increase the charges billed to ERISA plan participants for hospital services. . . . This effect is no different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e. utility costs, the wages of its employees, waste disposal costs, etc. New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way. Nor does it deprive ERISA plans of any alternative they would otherwise

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[20] *In Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, Nos. 93-7547, 93-7573 & 93-7548, 1994 WL 513971, at *13 (3d Cir. Sept. 22, 1994), the Third Circuit, in dicta, suggested that this case may not directly conflict with *United Wire*, citing differences between New Jersey's and New York's hospital reimbursement schemes. However, the Plans and Empire respectfully submit that the *Keystone* Court misunderstands the operation of New York's hospital reimbursement scheme. The Plans received the benefit of the differentials because of their community rating, open-enrollment, and other socially responsible activities. This is directly analogous to New Jersey's granting of discounts for "quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole." *United Wire*, 995 F.2d at 1189. Furthermore, although not challenged in this action, New York's hospital rate-setting scheme also has a bad-debt and charity care component which must be paid by all payors, including the Plans. The bad-debt and charity care surcharge is currently being challenged on preemption grounds. *See Trustees of and the Pension, Hosp. Benefit Plan of the Elec. Indus. v. Cuomo*, No. 92-5589 (E.D.N.Y. filed Nov. 25, 1992). A ruling on the presently pending motions for summary judgment is expected after this Court renders its decision in this case. In any event, the Plans and Empire respectfully submit that the analysis of and test for preemption set forth in *United Wire* suffices to dispose of this action.

> have in these areas. Finally, since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

Id. at 1193.

The *United Wire* majority further rejected the argument that because of their fiduciary responsibilities, ERISA plans were prohibited from "paying for hospital services . . . if any portion of the price paid [could] be viewed as attributable to the cost of providing services to others." *Id.* at 1195. Using words particularly applicable to the situation here, the Third Circuit reasoned that

> there are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices. . . . Such regulations can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind.

Id. at 1196.

The Third Circuit also found no merit in the suggestion that the statutes should be preempted because ERISA plans' participation was required for the statute to meet its social goals. *United Wire* stated that "it is of no legal consequence if removing ERISA plans from the scene would diminish the likelihood that the statute would meet its social goals. Rather, the test for preemption in this regard is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied." *Id.* at 1192 n.6.

In sum, ERISA does not preempt a

> generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out

> such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state.

Id. at 1195.

Furthermore, ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), the Second Circuit correctly recognized that New York State's hospital rate-setting and insurance regulatory scheme constituted a valid exercise of the State's police powers whose effect upon ERISA plans was too tenuous, remote and peripheral to be preempted.[21] In *Rebaldo*, the plaintiff trustee filed an action on behalf of a self-funded employee benefit plan arguing that ERISA preempted the predecessor to the statutes challenged in this action. *Rebaldo*, 749 F.2d at 134. Declining to find preemption, the Second Circuit rejected the argument that preemption follows because the law could increase the plan's cost of doing business. Finding that the argument "prove[d] altogether too much," *Rebaldo* reasoned:

> "That argument does not withstand scrutiny. So too, for example, do State laws and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted."

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[21] In *Ingersoll-Rand*, this Court rejected the argument that the narrower language of 29 U.S.C. § 1144(c)(2), which defines the term "State" for purposes of ERISA preemption, limited preemption to state laws which purport to regulate ERISA plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990). In *Travelers*, the Second Circuit relied upon this portion of *Ingersoll-Rand* to reject its prior decision in *Rebaldo*. (JA-51-52.) However, although a law need not purport to regulate ERISA plans to be preempted, it simply does not follow that the challenged statutes are preempted or that the remainder of *Rebaldo*'s analysis is no longer valid.

Id. at 138 (quoting *Lane v. Goren*, 743 F.2d 1337, 1340 (9th Cir. 1984)). In sum, *Rebaldo* correctly found that the laws at issue are not preempted because it

> follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. *A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.*

Id. at 138 (emphasis added).[22]

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[22] Applying the standards established by this Court, lower courts have found numerous laws of general application that may impact ERISA plans in some fashion not preempted by ERISA. *See Employee Staffing Serv., Inc. v. Aubry*, 20 F.3d 1038, 1042 (9th Cir. 1994) (finding that ERISA did not preempt a California law requiring employers to maintain a separately administered workers' compensation program and stating that "[t]he economic effect of independent state requirements on employers' incentives in drafting ERISA plans should be distinguished from the legal effect of state commands regarding ERISA plans"); *Keystone Chapter, Associated Builders and Contractors, Inc. v. Foley*, Nos. 93-7547, 93-7573 & 93-7548, 1994 WL 513971 (3d Cir. Sept. 22, 1994) (upholding Pennsylvania minimum wage law against ERISA preemption challenge); *Retirement Fund Trust v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990) (concluding that California tax collection procedures were not preempted by ERISA); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (stating that ordinance imposing a municipal income tax was not preempted); *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984) (determining that ERISA did not preempt statute prohibiting employment discrimination); *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994) (holding that ERISA did not preempt Minnesota's health care provider tax); *WSB Elec., Inc. v. Curry*, Nos. 90-0971 & 90-01109, 1994 WL 446039 (N.D. Cal. Aug. 11, 1994) (stating that ERISA did not preempt California statute governing wages which contractors on certain public work projects are required to pay their employees).

B. The Second Circuit Ignored ERISA's Legislative History as Well as the Strong Presumption Against Preemption For Legislation Enacted Within the States' Police Powers

Not only did the Second Circuit misapply this Court's ERISA preemption analysis, it ignored (1) the broader context of Congress' purpose in enacting ERISA and (2) the strong presumption against preemption where the challenged law was based upon the states' traditional police powers.

There is a presumption against preemption particularly where, as here, the State has enacted legislation within its traditional police powers. As explained by this Court in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981), "Our analysis of [ERISA preemption] must be guided by respect for the separate spheres of governmental authority preserved in our federalist system. . . . '[P]re-emption of state law by federal statute or regulation is not favored "in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained."' " (Quoting *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981).) Furthermore, " 'we start with the assumption that the historic police powers of the States were not to be superseded by the [federal legislation] unless that was the clear and manifest purpose of Congress.' " *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 206 (1983) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Without question, New York State's hospital rate-setting and insurance regulatory scheme is a law enacted within the states' historic police powers. And, Congress did not express the necessary "clear and manifest purpose" of preempting state hospital rate-setting and cost control schemes. In fact, in ERISA's entire legislative history it is never even mentioned

or suggested that preemption may impact state efforts to legislate in the healthcare arena.

Congress apparently did not contemplate that ERISA's preemption clause would be construed to preclude states from enacting legislation designed to control hospital costs.[23] Representatives of state governments (other than insurance commissioners) did not play a role in the enactment of ERISA or its preemption clause. P. Butler, National Governors' Association, *Roadblock to Reform ERISA Implications for State Health Care Initiatives* 4 (1994). And since "most health policy analysts and state and federal policymakers firmly believed in 1974 that a national program was imminent[,] . . . states and other interest groups might not have seen the threat of ERISA preemption." *Id.* at 4-5. More importantly, at the time ERISA was enacted, some states had already begun setting hospital rates, yet "no one suggested that ERISA might undermine this authority." *Id.* at 5.

Congressional action in closely related matters also suggests that Congress had no intention of precluding states from enacting hospital cost control legislation. As set forth more fully in the Brief of HANYS, in legislating in the area of healthcare, in particular the Medicare and Medicaid programs, Congress has encouraged states to implement cost control systems applicable to all payors while, at the same time, recognizing that different payors could be required to pay dif-

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[23] The historical environment surrounding the enactment of a statute provides further insight into congressional intent. *United States v. Wise*, 370 U.S. 405 (1962) ("[S]tatutes are construed by the courts with reference to the circumstances existing at the time of the passage."); *Lewis v. Hegstrom*, 767 F.2d 1371, 1376 (9th Cir. 1985) ("[I]n construing a statute we are duty bound to 'consider time and circumstances surrounding the enactment as well as the object to be accomplished by it.' ") (quoting *Callejas v. McMahon*, 750 F.2d 729, 731 (9th Cir. 1984)); *Roe v. Norton*, 522 F.2d 928, 935 (2d Cir. 1975) ("A statute must be construed with reference to the circumstances existing at the time of its passage and in the light of the conditions under which Congress acted at the time.").

ferent amounts for the same services. In fact, the predecessor to the statutes challenged in this action (which included a 12%-15% differential) was enacted as part of a federally approved experiment and demonstration project adopted in connection with the federal Medicare program. *See Rebaldo v. Cuomo*, 749 F.2d 133, 136 (2d Cir. 1984).

Here, New York State has chosen to regulate hospital rates and insurance in the manner which it has determined best achieves its policy objective of increasing access to affordable health insurance by controlling hospital costs. Regardless of the wisdom or effectiveness of New York's choice, the absence of evidence that Congress clearly intended to preclude such state efforts and the need to "respect the separate spheres of governmental authority preserved in our federalist system" underscores that New York's statutory scheme must stand.

II.

IN ANY EVENT, ERISA'S "SAVING CLAUSE" EXEMPTS THE NEW YORK STATUTES FROM PREEMPTION

The strong presumption against preemption recognized in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981), applies here in regard to the State's exercise of its traditional police powers to enact a comprehensive hospital rate-setting and insurance regulatory scheme. Indeed, "[w]hen the States speak in the field of 'insurance,' they speak with the authority of a long tradition. For the regulation of 'insurance,' though within the ambit of federal power, has traditionally been under the control of the States." *SEC v. Variable Annuity Life Ins. Co. of America*, 359 U.S. 65, 68-69 (1959) (citation omitted).

Thus, to protect the states' police powers in regard to the regulation of insurance, Congress explicitly carved out laws

that regulate insurance from the scope of ERISA preemption by enacting a "saving clause" which provides:

> Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. § 1144(b)(2)(A) (1988).[24] Due to the states' traditional powers in the field of insurance, the saving clause must be broadly construed. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741 (1985). And, in fact, preemption is "substantially qualified by [ERISA's] saving clause." *Id.* at 733. Here, as laws regulating insurance, the 11% and 13% differentials are saved from preemption.[25]

In determining whether a law is saved from preemption, this Court has looked first to "what guidance [is] available from a 'common-sense view' of the language of the saving clause." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (citing *Metropolitan Life Ins. Co.*, 471 U.S. at 740). Second, this Court has looked to cases interpreting the meaning of "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*; *see Pilot Life Ins. Co.*, 481 U.S. at 48. As stated in *Metropolitan Life Insurance Co.*:

> Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within the Act's reference to the "business of insurance"; "*first*,

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[24] Title 29 U.S.C. § 1144(b)(2)(B) (1988), the "deemer clause," limits operation of the saving clause by providing that an employee benefit plan cannot be deemed to be an insurer for purposes of any law of any state purporting to regulate insurance. This clause is not at issue here because the district court injunction against application of the differentials was issued only as to "commercial insurers and HMOs" and did not include self-insured plans. (A-89-90.)

[25] The United States has taken the position that the 9% differential is also saved from preemption as a law regulating insurance.

> whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry."

471 U.S. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)) (emphasis in original). None of these criteria alone is determinative. *Union Labor Life Ins. Co.*, 458 U.S. at 129.

These two tests, the common sense test and the McCarran-Ferguson Act factors, must be applied in a manner consistent with "the role of the saving clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 51. The traditional police power to regulate insurance was reserved to the states, *Metropolitan Life Ins. Co.*, 471 U.S. at 744 n.21, and these tests must be applied to save such regulation. Despite such guidance, the Second Circuit never considered the legislative history of the differential, as developed in the Record, ignored the role of the differentials in promoting the availability of insurance in New York State and, therefore, concluded that the differentials applied only to hospital rates and not insurance—a conclusion that wars with common sense.

The Second Circuit also ruled that the differentials only meet the first of the three McCarran-Ferguson Act criteria. Although the Second Circuit found that the differentials spread risk, the Court ruled that the differentials "do not regulate any practice that is integral to the insurer-insured relationship," because they "do not directly change any of the terms, conditions or scope of coverage in commercial insurance contracts." *Travelers*, 14 F.3d at 723. (JA-59.) Again, the Second Circuit so ruled by ignoring the stated purpose of the differential—to provide access to affordable insurance—which is certainly a goal integral to the insurer-insured relationship. The Second Circuit continued to close its eyes to the

purpose of the differentials when it ruled that the differentials are not " 'limited to entities in the insurance industry,' " because they "involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds." *Id.* at 723 (quoting *Pilot Life*, 481 U.S. at 49). (JA-60.)

A. The Differentials Regulate Insurance From a Common Sense Perspective

The Second Circuit ignored the dual role that the differentials play both in controlling hospital costs and in regulating insurance in finding that the challenged statutes do not regulate insurance as a matter of common sense. It simply does not follow that because the challenged statutes regulate hospital rates, they cannot also regulate insurance in a manner that fulfills that State's policy objective of increasing the availability of affordable health insurance. The challenged differentials were directed at and designed to impact the underwriting and premiums setting practices of persons in the insurance industry. That certain insurers pay less for hospital services than other payors was part of a long term, clearly articulated legislative effort to affect the health insurance market in order to increase the availability of coverage. (Record; *see generally* Antonini Aff.) In fact, the sole factor determining the payment of the differentials is the payor's status in the insurance marketplace.

Likewise, only a conclusion-driven formalism could attribute significance to the fact that the challenged differentials are contained in the Public Health Law rather than the Insurance Law. This Court has long recognized that nothing in ERISA's saving clause "purports to distinguish between traditional and innovative insurance laws." *Metropolitan Life*, 471 U.S. at 741. Indeed, in *United States Department of the Treasury v. Fabe*, this Court ruled that a priority statute was a law regulating insurance stating that " 'mere matters of form need not detain us.' " 113 S. Ct. 2202, 2210 (1993) (quoting

SEC v. National Sec., Inc., 393 U.S. 453, 460 (1969)); *see FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (determining that an anti-subrogation law regulates insurance from a common sense perspective); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt. Corp.*, 995 F.2d 500, 503 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993) (finding that a state statute prohibiting "an insurer's unreasonable restriction of the insured's choice of physician and hospital" is the regulation of insurance from a common sense perspective, "albeit indirectly through the structure of the [preferred provider organization]").

B. The Second Circuit Erred in Rigidly Applying the McCarran-Ferguson Act Criteria to Determine Whether the Challenged Differentials Are Saved From Preemption

While the McCarran-Ferguson Act criteria are instructive, none of them is determinative in evaluating whether the challenged differentials are saved from preemption. ERISA's saving clause broadly applies to "any person" subject to insurance regulation. By contrast, the McCarran-Ferguson Act gives authority to the states to regulate "the business of insurance, and every person engaged therein." 15 U.S.C. § 1012(a) (1988).[26] Thus, ERISA's saving clause sweeps more broadly

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[26] 15 U.S.C. § 1012 provides:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of

than the McCarran-Ferguson Act and encompasses insurance regulation generally—not just core activities constituting "the business of insurance." *See Metropolitan Life*, 471 U.S. at 746, n.24 ("[T]he saving clause is broad on its face and specific in its reference."). Furthermore, in *United States Department of the Treasury v. Fabe*, 113 S. Ct. 2202 (1993), this Court moved away from strict application of the three prong test in determining whether a state preference statute applicable to an insolvent insurer regulated insurance. In *Fabe*, this Court stated that the "business of insurance" was not confined entirely to the writing of insurance contracts, but included the performance of the insurance contracts as well. *Id.* at 2209. This Court noted that in *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), and *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), only "ancillary activities" to the performance of a contract were at issue, that is agreements with pharmacies and peer review activities, respectively. The "ancillary activities" engaged in by the insurers did not affect the payment of claims or the cost of coverage to policyholders and, therefore, did not involve the performance of a contract and were not the "business of insurance."

In *Fabe*, this Court also remarked that the McCarran-Ferguson Act factors were applied in *Royal Drug* and *Pireno* to evaluate whether insurer conduct was exempt from federal anti-trust law. *Fabe*, however, involved the scope of the first clause of § 2(b) of the McCarran-Ferguson Act, rather than the anti-trust exemption contained in the second clause. Distinguishing between the broader language of the first clause of § 2(b) and the narrower language of the anti-trust exemption, this Court reasoned:

> The language of § 2(b) is unambiguous as the first clause commits laws "enacted . . . for the purpose of regulat-

---

insurance to the extent that such business is not regulated by State Law.

> ing the business of insurance" to the States, while the second clause exempts only "the business of insurance" from the anti-trust laws. To equate laws "enacted . . . for the purpose of regulating the business of insurance" with the "business of insurance" itself, as petitioner urges us to do, would be to read words out of the statute. This we refuse to do.

Id. at 2209-10. That the language in the first clause of the McCarran-Ferguson Act should be read in a broader fashion than the anti-trust exemption comports with the statute's purpose. The first clause was "intended to further Congress' objective of granting the States broad regulatory authority" over insurance issues. On the other hand, the anti-trust exemption was intended by Congress "to carve out only a narrow exemption" from federal anti-trust law. *Id.* at 2210.

In the context of the ERISA saving clause, the Second Circuit erred in applying the McCarran-Ferguson Act factors as if the anti-trust exemption were at issue. Here, the differentials are not "ancillary activities" of insurers with no impact on policyholders; rather, the differentials are State designed incentives to encourage broad access to affordable insurance coverage. The language of the ERISA saving clause, like the language of the provision at issue in *Fabe*, is also broader than the anti-trust exemption under which the McCarran-Ferguson factors are generally applied. Like the first clause of § 2(b) of the McCarran-Ferguson Act, the saving clause should be read broadly to protect the states' regulatory authority over insurance, not narrowly like the limited exemption from the anti-trust law. *See Metropolitan Life Ins. Co.*, 471 U.S. at 744 n.21. As such, rigid application of the McCarran-Ferguson Act factors in this case is as inappropriate as it was in *Fabe*.

C. In the Context of ERISA's Saving Clause Language The Differentials Meet All Three of the McCarran-Ferguson Act Factors

1. The Differentials Spread Risk

The Second Circuit correctly found that the hospital differentials help spread the risk of healthcare costs over a broad section of the population. *Travelers*, 14 F.3d at 722-23. (JA-59-60.) The differentials allow insurers and HMOs to provide broad access to healthcare coverage at an affordable price by attracting good health risks into the same insurance programs as persons who are poor health risks. When more good risks participate in the same insurance programs as poor risks, the healthcare costs of persons who are ill are spread over a much larger portion of the population and coverage for all is affordable. This fits the classic definition of insurance and risk sharing. *See Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (citing R. Keaton, *Insurance Law* § 1.2(a) (1971)) (defining insurance as "an arrangement for transferring and distributing risk"). Without the availability of coverage, no risk transferring would occur. *See Fabe*, 113 S. Ct. at 2209; *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt. Corp.*, 995 F.2d 500 (4th Cir. 1993).

2. The Differentials Are Integral to the Insurer-Insured Relationship

The Second Circuit, however, erred in determining that the differentials "do not regulate any practice that is integral to the insurer-insured relationship." *Travelers*, 14 F.3d at 723. (JA-59.) Whether individuals can obtain coverage and the cost of that coverage are undoubtedly at the core of the relationship between the insured and the insurer, and both of these concerns are directly affected by the differentials. The differentials encourage insurer practices that lower barriers to obtaining health insurance and help ensure that persons who most need coverage can obtain it, *e.g.*, that applicants are not

denied coverage because of prior or current illness or hazardous occupation and that there is sufficient risk sharing among healthy and ill persons so that coverage is affordable.[27] Furthermore, whether the insurer engages in community rating to establish premiums affects the price of a policy as well as the rate that the premiums will increase over the years. As stated in *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), "[c]ertainly the fixing of rates is part of [the business of insurance]." Without question, the enrollment process and cost of obtaining coverage, which determine whether the formation of an insurance relationship will occur, are as important to the insured as the items covered under the contract.

Additionally, the Second Circuit's conclusion that in order to meet the second prong of the McCarran-Ferguson Act test the regulation had to affect an actual contract term is clearly incorrect under this Court's decision in *United States Department of the Treasury v. Fabe*, 113 S. Ct. 2202, 2209 (1993). *Fabe* found a priority statute for creditors of an insolvent insurer to be integral to the relationship between the insurer and the insured because the insolvency statute ensured payment of the policyholders' claims, that is, performance of the contract. Thus, the Court focused its inquiry upon whether the statutory term affects the "relationship between the insurance company and its policyholders" and not upon whether the statute dictated any of the policy terms. *Id.* Here, the differentials do indeed affect the relationship between the insurance company and its policyholder to the extent that coverage is

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[27] As noted *supra* note 8, the fact that commercial insurers are now subject to open enrollment and community rating if they choose to enter the individual and small group market is irrelevant. In extending the differential through 1995, the New York Legislature determined that serious access problems for individuals and Medicare supplemental subscribers still remain because commercial insurers are not mandated to provide individual or small group coverage.

available and the price to be paid for such coverage is more affordable.[28]

Other circuit courts have correctly applied this McCarran-Ferguson Act factor in a broader fashion. In *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield*, 883 F.2d 1101, 1108 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990), the court stated:

> The exemption offered to state-regulated insurance activities . . . would be thin indeed if it were deemed to cover the content of policies, but not the marketing and pricing activities which necessarily accompany these policies.

More recently, in *Stuart Circle Hospital Corp. v. Aetna Health Management Corp.*, 995 F.2d at 500, 503 (4th Cir. 1993), the court held that "treatment and cost are important components

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[28] *In Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), this Court found that Blue Shield's arrangement with certain pharmacies to charge insureds only two dollars for every prescription drug did not constitute the business of insurance under the McCarran-Ferguson Act. The Court's finding that the agreements were not integrally related to the insurer-insured relationship is clearly distinguishable from the situation presented here. The pharmacy agreements formed part of the insurers' own ordinary cost reduction efforts and were undertaken in the normal course of business. Although the differentials affect the amounts paid to hospitals, the price difference operates to prompt the Plans and HMOs to offer a fundamentally different insurance product—where traditional insurance underwriting practices are discarded and consumers' efforts to consummate the purchase of insurance contracts are rendered far easier. Open enrollment, community rating and other activities stimulated by the differential are not activities that insurers would naturally undertake if they were simply attempting to compete on the basis of price. Accepting all applicants for insurance when one's competitors do not is not a cost reduction activity undertaken in the normal course of business. In fact, open enrollment operates against the insurer's business interests. (JA-201-03, 291-92.) Therefore, unlike the business decision made in *Royal Drug*, the differentials operate as a legislative incentive to consummate the contractual relationship between the insurer and the insured.

of health insurance," and therefore are integral to the contractual relationship.

3. The Differentials Are Key to State Regulation of New York's Insurance Industry

The Second Circuit erred in determining that the differentials are not a practice limited to entities in the insurance industry. To meet this test, the practice does not have to be limited to insurers; rather, the test is whether the practice is directed at the "insurance industry." The fact that hospitals were involved in the collection of the 11% differential or are allowed to retain the 13% differential does not mean that the purpose of the challenged scheme is not insurance regulation. The Second Circuit's conclusion focused only on the differentials' role in regulating and controlling hospital rates, while ignoring the long-recognized State policy of using the differentials to attain broad access to insurance in New York.

Only those participants in the insurance industry that historically bore the burden of providing open enrollment to all persons regardless of health, age, sex or occupation, that is the Plans and the HMOs, could benefit from the 13% differential. In fact, until April 1, 1992, the statute specifically required the Plans to continue broad open enrollment policies in order to avoid losing a portion of the differential. (JA-227.) Conversely, the statute offered the incentive to commercial insurers to avoid a portion of the differential if they instituted open enrollment. None of the commercial insurers took advantage of this incentive. (JA-228.) Thereafter, the 11% differential, targeted specifically at and paid only by commercial insurance companies, was enacted to extend the regulatory effort to encourage broader enrollment policies and to help compensate for the commercial insurers' increasingly aggressive selection of good risks out of the Plans' community pools. Thus, the differentials are specifically directed at New York's health insurance industry and are central to the State's efforts to regulate that industry in a manner which promotes access to affordable health insurance coverage.

D. HMOs Which Benefit From the Differentials Are Persons Subject to Insurance Regulation

The Second Circuit erred in finding that HMOs are not insurers "as a matter of law." The Second Circuit then greatly compounded this error by concluding that, because under its view HMOs are not insurers, a law could not regulate insurance within the meaning of the saving clause if it included HMOs within its reach. The Second Circuit made such a finding on this important issue without even considering the language of the saving clause itself, which extends to "person[s]" subject to laws which "regulate[ ] insurance." 29 U.S.C. § 1144(b)(2)(A) (1988). Nor did the court address any of the substantial case law that correctly recognizes the insurance function of HMOs. The nature of the challenged differentials, the treatment of HMOs under New York law, as well as numerous decisions of lower courts demonstrate that HMOs qualify as "persons" subject to insurance regulation. And it necessarily follows that HMOs are entities in the insurance industry.

Narrowing the application of the saving clause to traditional insurers ignores the monumental changes that have occurred in the insurance marketplace. *See Fabe*, 113 S. Ct. at 2211-12; *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir.), *cert. denied*, 464 U.S. 822 (1983). The differences between HMOs and traditional insurers are becoming narrowed or, in fact, have been eliminated. There are many different types of HMOs and the degree to which the delivery of care by an HMO differs from traditional insurance is dependent on the type of HMO. In a staff or group model HMO, comprehensive medical benefits are offered with nominal out of pocket expenses and care is provided by physicians salaried by the HMO. If there is any meaningful distinction between an HMO and an insurer, it attaches to this model alone and only in its purest form. By contrast, almost all of the plaintiff HMOs are organized as individual practice association ("IPA") model HMOs, which contract with privately practicing physicians

who provide medical services and deliver care in their own offices. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993); *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210, 1211 (3d Cir. 1993); *Health Care Plan, Inc. v. Aetna Life Ins. Co.*, 966 F.2d 738, 739 (2d Cir. 1992). However, the fact that some HMOs may deliver care (staff models) or arrange for care (IPA models) does not affect the role that HMOs play with members—they provide health-care services for a fixed fee.

In order to compete and to provide cost effective attractive products to consumers, many traditional insurers, including the Plans, have their own IPA HMOs and, in addition, offer managed care products which are identical to HMO products. On the flip side, HMOs have always covered certain services such as hospital, emergency and out of area services and are now expanding coverage outside the HMO network with new product lines. In fact, HMOs were recently given explicit statutory authority to offer coverage for what is referred to as "point of service" benefits. In other words, HMO members can now obtain covered benefits from the HMO for care rendered by providers unaffiliated with the HMO. Specifically, N.Y. Pub. Health Law § 4406(2)(a), enacted in July 1993, allows HMOs to "implement an out-of-plan benefits system that allows enrollees to use providers not participating in the plan." Thus, the difference between insurers and HMOs is "elusive" because of the movement of each to the other.[29] *See In re Estate of Medcare HMO*, 998 F.2d 436, 444 n.7, 445 n.9 (7th Cir. 1993).

In any event, when HMOs reimburse hospitals for providing services to their subscribers, all HMOs function like

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[29] Recently, the Internal Revenue Service concluded that IPA model HMOs qualify as insurance companies for federal tax purposes in that the HMOs' "contracts with their members satisfy the risk shifting and risk distribution requirements for insurance." Technical Advice Memorandum, dated Dec. 17, 1993, IRS Letter Ruling Reports 9412002 (CCH).

insurers. Like the commercial insurers and the Plans, HMOs accept the risks of providing hospital care and indemnify their subscribers for such costs in exchange for a premium payment. *See* N.Y. Pub. Health Law §§ 4401(1)-(2) (McKinney 1985 & Supp. 1994).[30]

Although the Second Circuit correctly stated that HMOs do not have to be licensed as insurers in New York, N.Y. Ins. Law § 1109(a) (McKinney Supp. 1994), HMOs receive only a limited exemption from the insurance laws. In fact, N.Y. Ins. Law § 1109, entitled "Limited Exemption For Health Maintenance Organizations," states explicitly that HMOs must comply with New York's Insurance Law as required by the Public Health Law and as specifically set forth in section 1109(a). The insurance requirements include: (1) mandated benefit requirements, N.Y. Pub. Health Law § 4406 (McKinney Supp. 1994); (2) prior approval of premium rates, N.Y. Pub. Health Law § 4403(1) (McKinney 1985 & Supp. 1994); N.Y. Ins. Law § 4308 (McKinney 1985 & Supp. 1994); and (3) approval of subscriber contracts by the Superintendent of Insurance "as if it were a health insurance subscriber contract." N.Y. Pub. Health Law §§ 4402(2)(f), 4406(1) (McKinney 1985 & Supp. 1994).[31] Most significantly, HMOs

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[30] N.Y. Pub. Health Law defines an HMO as an entity which "enter[s] into an arrangement [with a person or group] . . . which propose[s] to provide or offer . . . a comprehensive health services plan." N.Y. Pub. Health Law § 4401(1). A comprehensive health services plan is a plan under which a subscriber "is entitled to receive comprehensive health services in consideration for [a premium payment]." N.Y. Pub. Health Law § 4401(2). Under 10 N.Y.C.R.R. § 98.2(v), an HMO premium is defined as "the amount of money the HMO charges each enrollee for the specified benefit package."

[31] Additional regulation of HMOs as insurers under New York law includes: examinations of financial affairs by the Superintendent of Insurance, N.Y. Pub. Health Law § 4409(2) (McKinney 1985); payment of assessments for the expenses of the Insurance Department, N.Y. Ins. Law §§ 1109, 332 (McKinney 1985 & Supp. 1994); limitations on borrowing and pledging assets, N.Y. Ins. Law § 1307 (McKinney 1985); liquidation,

must engage in community rating and open enrollment and, therefore, like the Plans, obtain the benefit of the differentials. N.Y. Pub. Health Law § 4406; N.Y. Ins. Law § 4317 (McKinney Supp. 1994); 10 N.Y.C.R.R. §§ 98.2(u), 98.5(b)(18); 11 N.Y.C.R.R. § 52.42.

Case law further supports finding that HMOs function as insurers because they spread risk and cover the cost of healthcare. Recently, the Seventh Circuit stated that:

> Because HMOs spread risk—both across patients and over time for any given person—they are insurance vehicles . . . .

Anderson v. Humana, Inc., 24 F.3d 889, 892 (7th Cir. 1994).

In re Estate of Medcare HMO, 998 F.2d 436 (7th Cir. 1993), ruled that HMOs are domestic insurers under the Bankruptcy Code.[32] Although the HMOs are not required to be licensed as insurers in Illinois, in *Medcare* the court nevertheless found that because an HMO agreed to arrange for medical and hospital services in exchange for premium payments, the HMO had accepted the risk and performed an insurance function. "[T]he distinction between cash indemnification and provision of service in kind is not . . . very marked. The enrollees' healthcare costs are met . . . under either scenario." *Id.* at 444 n.7. Similarly, in *Physicians Health Plan, Inc. v. Citizens Insurance Co. of America*, 673 F. Supp. 903 (W.D. Mich. 1987), the court specifically determined that HMOs are insurers for purposes of applying the "saving clause":

> HMOs and insurance companies share the indicia of the "business of insurance." Both assume the risk that their members or insureds will require benefits in excess

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rehabilitation and dissolution requirements, N.Y. Ins. Law § 1109(c) (McKinney 1985); and restrictions on investments, N.Y. Ins. Law § 1109(d) (McKinney 1985).

[32] Other courts have come to the same conclusion. *See In re Family Health Services, Inc.*, 143 B.R. 232 (C.D. Cal. 1992); *In Re Portland Metro Health, Inc.*, 15 B.R. 102 (D. Or. 1981).

> of the consideration paid. . . . In either scheme, the principle is the same: for a fixed fee, the risk and responsibility of providing benefits is shifted from a beneficiary to a third party insurer.

Id. at 907. *See Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir. 1983) (finding that a prepaid health plan which provided pharmacy services directly to its subscribers, rather than monetary indemnification for pharmacy supplies, fell within the "business of insurance" as set forth in the McCarran-Ferguson Act even though the plan was more like a healthcare provider).

The Second Circuit's finding that HMOs are not "insurers" for ERISA purposes dangerously insulates HMOs from insurance regulation and has a significant negative impact on the states' ability to regulate the health insurance marketplace.[33] This makes no sense considering the competition between insurers and HMOs[34] and the identical healthcare benefits

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[33] In fact, as a result of the Second Circuit's statement that HMOs are not insurers, HMOs have already been allowed to escape important insurance reforms on the grounds of ERISA preemption. In *New York State Health Maintenance Organization Conference v. Curiale*, No. 93-1298, transcript of hearing at 3 (S.D.N.Y. Feb. 25, 1993), the district court followed *Travelers* stating that the demographic pooling regulations, the financing mechanism for the open enrollment and community rating legislation, could not be saved because the regulations were applicable to HMOs. *Compare Health Maintenance Organization of New Jersey v. Whitman*, No. 93-5775, 1994 WL 549626 (D.N.J. Oct. 3, 1994) (following *United Wire* and upholding New Jersey's 1992 insurance reform legislation because the court was "unwilling to frustrate New Jersey's efforts to regulate healthcare costs").

[34] It is interesting to note that in *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993), U.S. Healthcare, Inc., a member of respondent New York State Health Maintenance Organization Conference attempted to define the relevant market as limited to HMOs for purposes of determining whether an exclusive dealing clause in an HMO service agreement violated the anti-trust laws. The Court of Appeals for the First Circuit declined to do so finding the relevant market to be all health care financing which includes insurers, the Blue

offered by insurers and HMOs. Moreover, it evinces a clear misunderstanding of how HMOs operate and are regulated by the states. In New York, the legislature has determined that HMOs are to be regulated as insurers in regard to some aspects of their business. The State has also recognized that it remains appropriate for HMOs to be regulated as healthcare providers for issues such as the quality of care. However, since at all times HMOs are accepting risk pursuant to the dictates of Insurance Law § 1109(a), the State has directed that HMOs are to be regulated by the Superintendent under the Insurance Law. This dual regulation also properly reflects the legislative policy behind New York's enabling legislation for HMOs, Article 44 of the Public Health Law, which was designed

> to allow HMOs to provide [healthcare] services without being hampered by the strict requirements of the State's Insurance Law; at the same time, . . . the HMO contract itself must nonetheless be regulated by the State's Insurance Department, rather than the Department of Health. (1976 Legislative Annual 240-242).

U.S. Healthcare, Inc. v. Curiale, 615 N.Y.S.2d 239, 240 (Sup. Ct. N.Y. Co. 1994) (upholding the authority of the Superintendent to regulate HMO premium rates). Regulation of HMOs in such a fashion also reflects the reality of an insurance marketplace which includes HMOs. Thus, the Second Circuit clearly erred in reaching the opposite conclusion.

Cross and Blue Shield Plans and other entities. *Id.* at 599. Similarly, in *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates*, 996 F.2d 537, 547 (2d Cir.), *cert. denied*, 115 S. Ct. 388 (1993), the Second Circuit considered the market as including "non-HMO Sources."

CONCLUSION

For all of the foregoing reasons, the decision of the Second Circuit Court of Appeals that ERISA preempts New York's differentials should be reversed.

Dated: New York, New York
November 15, 1994

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

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QUESTION PRESENTED

Whether Section 514(a) of the Employee Retirement Income Security Act of 1974 preempts New York laws that impose substantial surcharges on the hospital costs incurred by employee benefit plans in an effort to induce such plans to select a particular type of health care coverage.

RULE 29.1 STATEMENT

This brief is submitted on behalf of the following respondents, whose parent companies and subsidiaries (except wholly owned subsidiaries) are indicated below, pursuant to Supreme Court Rule 29.1.

1. **The Travelers Insurance Company**

   Parents: The Travelers Inc. (formerly Primerica Corporation, successor to The Travelers Corporation); Associated Madison Companies, Inc.; and The Travelers Insurance Group Inc.

   Subsidiaries: Applied Expert Systems, Inc.; and Primerica Financial Services Ltd.

2. **The Travelers Health Network of New York, Inc.**

   Parents: The Travelers Inc.; Associated Madison Companies, Inc.; The Travelers Insurance Group Inc.; The Travelers Insurance Company; The Travelers Employee Benefits Company Inc.; The Travelers Health Company; and The Travelers Health Network, Inc.

3. **Health Insurance Association of America**

   None.

4. **American Council of Life Insurance**

   None.

5. **Life Insurance Council of New York, Inc.**

   None.

6. **Aetna Life Insurance Company**

   Parent: Aetna Life and Casualty Company.

Subsidiaries: Aetna Health Plans of Florida, Inc.; Partners Health Plan of Pennsylvania, Inc.; Aetna Series Fund, Inc.; Med Southwest, Inc.; PHPSNE Parent Corporation; and Smith Whiley & Company.

7. **Aetna Health Plans of New York, Inc.**

Parents: Aetna Life and Casualty Company; Aetna Life Insurance Company; AHP Holdings, Inc.; and HEALTHWAYS Systems, Inc.

8. **Mutual of Omaha Insurance Company**

Subsidiary: Preferred HealthAlliance, Inc.

9. **The Union Labor Life Insurance Company**

Parent: Ullico Inc.

10. **Professional Insurance Agents of New York, Inc. Trust**

None.

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STATEMENT OF THE CASE

The State of New York has enacted statutes imposing substantial surcharges on the hospital costs incurred by patients covered by any form of health plan other than Blue Cross/Blue Shield (the Blues) or governmental insurance such as Medicaid. These surcharges, as the State has acknowledged, were expressly designed to "increase hospital costs for patients covered by health plans other than the Blues" (J.A. 52) and thereby to assist the Blues "in their competition with commercial insurers" (J.A. 165-66). Following numerous decisions of this Court, both courts below held that the state laws were preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a), because they "purposely interfere with the choices that ERISA plans make for health care coverage" and "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," which in turn would "lead plans to reduce their level of service or benefits." Pet. App. A22, A23.[1]

A. The New York Surcharge Statutes.

1. Most Americans (excluding those qualifying for programs like Medicare and Medicaid) receive their health care coverage through employee welfare benefit plans subject to ERISA. According to an independent study published in 1992, of the 158.3 million non-elderly Americans who have private health insurance, 138.7 million – roughly 88% – receive such coverage through their employers. J.A. 125. None of the petitioners challenged this fact in the courts below. Indeed, they concede in this Court that "ERISA plans are a major source of private health care coverage" (N.Y.Br. 10), and that "[i]t is undisputed that members of ERISA plans are significant consumers of hospital services" (HANYS Br. 24 n.19).

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[1] "Pet. App." refers to the appendix to the petition in No. 93-1414.

See also U.S. Bureau of the Census, STATISTICAL ABSTRACT OF THE UNITED STATES 118 (114th ed. 1994); U.S. Br. 4.

Employers and other plan sponsors that establish ERISA welfare plans must choose among a number of alternatives in providing health and hospital coverage to their employees. Many ERISA plans enter into health insurance contracts with a commercial insurer, which reimburses certain health care costs incurred by plan participants in return for a premium calculated to cover the costs of paying the claims and administering the policy. Other ERISA plans engage in self-insurance, whereby the plan itself is directly responsible for medical and hospital bills. Yet other ERISA plans choose to subscribe to an HMO, which is paid a predetermined rate in return for providing health care services to plan participants. Finally, some ERISA plans obtain coverage through non-profit health service corporations such as Blue Cross/Blue Shield. J.A. 35-36, 123-24.

2. Like a few other states,[2] New York regulates the rates at which hospitals are reimbursed for the costs of inpatient care. As a general rule, the rates for inpatient hospital care are determined on the basis of categories, known as "Diagnosis Related Groups" or "DRGs," that depend upon the diagnosis of a patient's illness rather than the actual cost of treatment. Pursuant to this system, hospitals charge patients the rate applicable to their assigned DRG, subject to certain adjustments reflecting costs specific to that hospital. Pet. App. A7; J.A. 152. Respondents have never challenged this even-handed aspect of New York's Prospective Hospital Reimbursement Methodology (NYPHRM), which has been in effect for more than a decade.

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[2] The brief filed by the National Governors' Association, *et al.*, as *Amici Curiae* (NGA Br. 18 n.11) identifies three states in addition to New York -- Maine, Maryland and West Virginia -- that have mandatory hospital rate-setting laws.

Unique among the states, however, New York provides that the amount charged to a patient is then increased by a "payor factor," depending solely upon the type of health care coverage protecting the patient. New York Public Health Law Section 2807-c(1)(b), enacted in 1988, requires that the DRG rate for inpatient services be increased by a 13% surcharge when the patient is covered by any form of health plan (including self-insurance) other than the Blues, an HMO, or government plans such as Medicare. The funds generated by the 13% surcharge are retained by the hospitals. Pet. App. A7.

In addition, New York's Omnibus Revenue Act of 1992 (Omnibus Act) imposed two more surcharges. First, Section 348 of the Omnibus Act amended Section 2807-c(11)(i) of New York's Public Health Law to impose an 11% surcharge on DRG payment rates charged by hospitals to patients covered by commercial insurance. Consequently, the total surcharge for commercially insured patients -- and thus the differential between the Blues' and commercial insurers' charges -- was set at 24%. In contrast with the funds generated by the 13% surcharge, the proceeds of the 11% surcharge ultimately are paid into the State treasury. Pet. App. A8.

Second, Section 346 of the Omnibus Act (codified at N.Y. Pub. Health Law § 2807-c(2-a)(a)) created a new surcharge of up to 9% on the cost of inpatient hospitalization paid by HMOs. This surcharge may be reduced or eliminated for HMOs that enroll a specified number of Medicaid patients. Like the 11% surcharge, the 9% surcharge ultimately is deposited into the State's general fund. Pet. App. A8.[3]

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[3] Current New York law retains the 13% surcharge. The 11% surcharge applied only to patients discharged between April 1, 1992, and March 31, 1993, and is no longer in force. The life of the 9% surcharge has been extended to December 31, 1995. See 1995 N.Y. Laws, ch. 731, § 35.

B. The Proceedings In This Case.

1. *Respondents' Lawsuit.* In the summer of 1992, respondents brought suit in the United States District Court for the Southern District of New York, seeking to enjoin the State from enforcing the surcharges against any commercial insurers, self-insurers or HMOs in connection with their coverage of any ERISA welfare benefit plans. Respondents contended that the state laws are preempted by Section 514(a) of ERISA, 29 U.S.C. § 1144(a), because they "relate to" employee benefit plans and are not saved as a regulation of insurance.[4] Petitioners New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York State intervened as defendants, and respondents New York State Health Maintenance Organization Conference and certain individual HMOs intervened as plaintiffs.

Respondents demonstrated in the district court that New York's surcharges substantially increased the costs to ERISA plans of providing benefits through commercial insurance, self-insurance, or HMOs. Because self-insured plans undertake to pay for covered medical services provided to their participants, they must pay the 13% surcharge directly. Similarly, commercial insurance policies often provide that the premiums charged will depend upon the amount of benefits paid. In that situation, the plans bear the burden of the 13% and 11% surcharges. More generally, the premiums charged for insurance, or the rates charged by HMOs, must be set at a level that will recapture the costs of providing benefits. State

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[4] Certain respondents also challenged the 13% and 11% surcharges on the ground that they are preempted by the Federal Employee Health Benefits Act, 5 U.S.C. § 8909(f)(1) (Supp. IV 1992). Also challenged on ERISA preemption grounds was a circular issued by the New York State Insurance Department entitled "Actuarial Information Letter No. 5." The court of appeals agreed with these contentions (Pet. App. A12-A17, A30-A34), which are not at issue in this Court.

laws increasing those costs -- here, the 13%, 11% and 9% surcharges -- directly increase the amounts that ERISA plans must pay to provide a given level of benefits. J.A. 133-34; 137; 140; 145.

For example, respondent Travelers Insurance Company introduced the following uncontradicted evidence. First, the 11% surcharge caused ERISA plans in New York to experience premium increases of from 2% to 5%. J.A. 299. Second, the 13% surcharge represented approximately 2% to 5% of the premiums paid by ERISA plans for group accident and health insurance. J.A. 300. Travelers also estimated that in the case of the Sheridan Catheter Plan (a self-insured fund for which Travelers provides claims administration services), the 13% surcharge would cost the plan approximately 2.4% of its health benefit costs for 1992. *Ibid.* Finally, Travelers estimated that for the period April 1, 1992 through April 1, 1993, the 13% surcharge would result in millions of dollars of added costs to the 91 self-insured ERISA plans for which it provides claims administration services, and that the 13% and 11% surcharges would result in added costs of many millions more to the ERISA plans covered by its commercial insurance policies. *Ibid.* Other commercial insurers and HMOs offered virtually identical experiences. See, *e.g.*, J.A. 133-34, 137-38, 140, 145.

Thus, the evidence adduced in the district court clearly demonstrated the practical impact of the New York statutes: an ERISA plan sponsor that chooses to provide medical benefits through commercial insurance, self-insurance or an HMO either must pay higher costs reflecting the surcharges to offer the same level of benefits or must reduce benefits to offset these additional costs. Moreover, these additional costs inevitably divert plan resources from the provision of health care benefits to plan participants, in order to subsidize the general revenue needs of the State of New York (in the case of the 11% and 9% surcharges) or hospitals' general revenue needs (in the case of the 13% surcharge). The impact of these

surcharges is enormous, costing plan sponsors or plan participants hundreds of millions of dollars annually. J.A. 303, 310, 327. The "obvious effect," as the court of appeals explained, "is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues." Pet. App. A8.

The evidence also demonstrated, not surprisingly, that New York adopted the surcharges for the very purpose of influencing the decision-making of plan sponsors. For example, New York's Deputy Superintendent of Insurance testified that the 13% surcharge was intended to provide a " 'level playing field' " to the Blues "in their competition with commercial insurers" in order to offset a perceived "competitive disadvantage of these not-for-profit corporations and an inability to maintain a mix of high, low and average risks." J.A. 165-66. See also J.A. 237 (quoting Governor Cuomo as stating that the surcharges were designed to provide "competitive support for Blue Cross"); J.A. 327, 334 (same). As the Blues candidly conceded in the district court, the surcharges were designed to permit them "to remain competitive" (J.A. 292), "to level the competitive marketplace" (J.A. 217), and to make purchasers of health insurance "think twice as hard" before choosing a commercial insurer. J.A. 207, 217-18, 232. Thus, it is undisputed that the statutes were enacted to drive the purchasers of health care coverage in New York (which overwhelmingly are ERISA plans) to the Blues in order to help them resolve their serious financial problems.[5]

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[5] Petitioners suggest (see N.Y. Br. 5; Blues Br. 9) that the Blues' financial crisis was attributable to competitive advantages by commercial insurers and a deterioration in the community-rated pools. In fact, the heart of Empire's deep financial crisis was not cherry-picking by HMOs and private insurers but rather the "gross mismanagement" of the company's own top executives, characterized by "wasteful expenditures, fraud, and a history of inattentiveness and non-action * * *." See *Oversight of the Insurance Industry: Blue Cross/Blue Shield -- Empire Plan (New York):*

(Footnote continued)

2. *The District Court's Decision.* The district court granted summary judgment for respondents, holding that the surcharges were preempted to the extent they applied to ERISA plans. Judge Freeh found that the surcharges fell within Section 514(a) of ERISA because they unquestionably "relate to" ERISA plans. First, the surcharges have a significant effect on insurers and HMOs providing coverage to ERISA plans and therefore lead to a substantial increase in plan costs. Pet. App. A71. Second, and "[m]ore importantly," the State's and the Blues' "entire justification for the [s]urcharges is premised on that exact result -- that the [s]urcharges will increase the cost of obtaining medical insurance through any source other than the Blues to a sufficient extent

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Hearings Before the Permanent Subcommittee on Invetigations of the Senate Committee on Governmental Affairs, 103d Cong., 1st Sess. 5 (1993). Significantly, the Subcommittee's staff found that the New York State Insurance Department, by blaming Empire's financial woes on "unfair competition" from profit-making insurers, had wholly abdicated its oversight responsibilities. *Id.* at 6, 143, 203-11. The Subcommittee also noted the allegations that Empire "used false data in order to convince the New York Legislature to pass landmark legislation in 1992." *Id.* at 2.

Petitioners also suggest (see N.Y. Br. 3; HANYS Br. 6) that the surcharges are justified as a reward for the Blues' "unique" community-rating and open-enrollment practices. But New York recently reenacted the 13% surcharge even though, effective April 1, 1993, New York now requires *all* insurers to adopt these practices in their underwriting of individual and small group plans. See N.Y. Ins. Law § 3231; N.Y. Br. 5; Blues Br. 9-10 n.8. Moreover, in the mid- and large-group markets, the Blues behave exactly like commercial insurers, offering experience-rated programs and self-insured claims administration services. J.A. 268, 275. The Blues' insured business nonetheless benefits in those markets from the competitive advantage of the 13% surcharge.

In response to the Blue's one-sided discussion of the "legislative history" of the differential (Blues Br. 10-13), we note that the state government body convened to review it concluded that its supposed social policy justifications were "subjective, conjectural and uncertain" (J.A. 279), and recommended that it be "phased out" in the absence of any "direct and quantifiable link * * * between the differential and appropriate social goals" (J.A. 283-84).

that customers will switch their coverage to and ensure the economic viability of the Blues." *Id.* at A72 (footnote omitted). Third, the surcharges "may [a]ffect the structure and/or administration of such plans." *Id.* at A73. Since commercial insurers and HMOs pass their increased costs on to covered plans, such plans "may reduce the level of benefits or services offered rather than increase costs to participants -- a burden on plan administration which ERISA was designed to avoid." *Id.* at A74. Finally, if covered plans chose to offset increased costs of benefits by changing benefit levels, the "[s]urcharges will, at least indirectly, impose inconsistent obligations upon multi-state plans -- exactly the type of burden ERISA's preemption clause was intended to prevent." *Ibid.*

Judge Freeh also concluded that none of the surcharges was "saved" from preemption as a regulation of insurance. He explained that the surcharges do not "relate directly to the policy relationship between the insurer and the insured" and are "not limited to the insurance industry." *Id.* at A81. In addition, "as defendants themselves appear to concede, the [s]urcharges' primary goal is to regulate hospital rates, not commercial insurers." *Id.* at A80.

3. *The Court of Appeals' Decision.* The Second Circuit unanimously affirmed. It agreed with the district court that the challenged surcharges "relate to" covered plans, and therefore are preempted by ERISA, because they

> are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage.* Such inter-

> ference is sufficient to constitute "connection with" ERISA plans.

Id. at A22 (emphasis added).

The court of appeals further found the requisite "relation to" ERISA plans by noting that the surcharges "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits" and thus "force ERISA plans either to increase plan costs or reduce plan benefits." Pet. App. A23. Therefore, the surcharges "have an impermissible impact on ERISA plan structure and administration." *Id.* at A24.

The court of appeals also agreed with Judge Freeh that the surcharges are not "salvaged by ERISA's savings clause as a law that regulates insurance." *Id.* at A25. To begin with, the Second Circuit found that the surcharges are not insurance regulations as a matter of common sense: "they aim to regulate hospital rates" and "do not address matters typically within the purview of state insurance regulations" (*id.* at A27). Furthermore, the surcharges met only one of the three criteria that this Court has identified as relevant in determining whether an otherwise preempted law "regulates insurance" within the meaning of the McCarran-Ferguson Act. They "do not regulate any practice that is integral to the insurer-insured relationship" and "are not 'limited to entities within the insurance industry.' " *Id.* at A28-A29 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 49 (1987)).

INTRODUCTION AND SUMMARY OF ARGUMENT

ERISA's preemption provisions have been a frequent subject of this Court's opinions. The "preemption clause" found in Section 514(a) of the statute -- which this Court repeatedly has described as remarkably broad -- preempts state laws that "relate to any employee benefit plan." Section 514(b) then creates several "narrow exceptions" to this rule of preemption (120 Cong. Rec. 29,197 (1974) (remarks of Rep.

Dent)), including one (the "savings clause") for state laws that "regulate[] insurance." Finally, the "deemer clause," Section 514(b)(2)(B), provides that an employee benefit plan may not "be deemed to be an insurance company * * * or to be engaged in the business of insurance * * * for purposes of any State law purporting to regulate insurance companies [or] insurance contracts"; this means that state insurance regulations are *not* saved from preemption as applied to self-funded plans.

As interpreted by this Court, the "relate to" language of the preemption clause is expansive, reaching *any* state law that has more than a tenuous effect on ERISA plans. In contrast, the "regulate" language of the insurance savings clause is narrowly focused, applying only to laws that address the terms and performance of insurance contracts, rather than those that more generally affect the insurance industry. Petitioners would turn this statutory structure on its head. They would narrow the preemption clause to reach only laws that directly regulate the terms of ERISA plans, while expanding the savings clause into a safe harbor for any law that has an impact on an insurance company. This statutory sleight-of-hand should be rejected.

This Court has made clear that the preemption clause reaches any law that has a connection with an ERISA plan, or that has any effect on plans that cannot be characterized as tenuous, remote, or peripheral. Under that test, New York's surcharges plainly are preempted. It could hardly be otherwise: the surcharges have the obvious effect -- and the avowed purpose -- of manipulating the selections made by ERISA plans (along with other consumers of health services) regarding arrangements for the payment of health benefits. The surcharges thus interfere directly with ERISA welfare plans' most basic administrative decisions. They also thwart ERISA's central purpose of establishing uniformity in the regulation of plans. Multi-state plans typically use a single

nationwide benefit payor to standardize procedures and reduce costs; New York's surcharges (especially if other states imposed charges reflecting different parochial preferences) would make such an approach difficult, if not impossible.

At the same time, New York's surcharges are not saved as regulations of insurance. This Court has held that the savings clause does not reach every law that has an impact on the insurance industry. Instead, the Court looks both to whether the law can be said to regulate insurance as a matter of common sense and to whether it satisfies the three-part test for identifying the business of insurance developed under the McCarran-Ferguson Act.

The New York surcharges fail both prongs of this inquiry. As a matter of common sense, the surcharges -- which in terms address hospital rates rather than insurance contracts -- bear no resemblance to insurance regulation, which is concerned with the relationship between the insurer and the insured. As for the McCarran-Ferguson Act test, (1) the surcharges do not regulate the spreading of risk because they do not address the risk that the *policyholder* seeks to transfer; (2) they do not regulate any part of the policy relationship between the insurer and the insured, which the Court has held to be wholly separate from ar[illegible]rrangements between the insurer and the health care pro[illegible]der; and (3) by their terms the surcharges are not limited to entities within the insurance industry. The surcharges accordingly are preempted by ERISA.

ARGUMENT

I. THE SURCHARGE LAWS FALL WITHIN ERISA'S EXPRESS PREEMPTION PROVISION BECAUSE THEY "RELATE TO" EMPLOYEE BENEFIT PLANS.

Section 514(a) states that, with certain exceptions not relevant here, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1988). That provision is "conspicuous for its breadth" (*FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990)), and this Court has repeatedly recognized its "expansive sweep." *Pilot Life*, 481 U.S. at 47; see also *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992) (" 'deliberately expansive' language"); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 137 (1990)("broad preemption provision"); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985)("broad scope"). Even petitioners are forced to acknowledge that "ERISA has broad preemptive scope." HANYS Br. 15.[6]

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[6] Despite this statement, petitioners and their amici (see, *e.g.*, Blues Br. 28-29; HANYS Br. 15; NGA Br. 3) seek to narrow the scope of preemption by invoking the canon that a state's exercise of its police powers should not be superseded unless that is the "'clear and manifest purpose of Congress.'" *Cipollone* v. *Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992) (citation omitted). But that principle -- which the Court typically has utilized in the context of implied preemption -- has no application where, as here, Congress has made its intent manifest by expressly preempting state law. As this Court has stated, ERISA's preemption provision "demonstrates that Congress intended to depart from its previous legislation that 'envisioned the exercise of state regulation power over pension funds,' * * * and meant to establish pension plan regulation as exclusively a federal concern." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522-23 (1981) (citation and footnote omitted). The only issue is one of statutory construction -- whether the challenged state law falls within the broad language chosen by Congress. See *Morales* v. *Trans World Airlines, Inc.*, 112 S. Ct. 2031, 2037 (1992).

In light of these precedents, both lower courts correctly concluded that the New York surcharge statutes are preempted by Section 514(a) because they unquestionably "relate to" ERISA benefit plans. The laws were expressly designed to affect, and in fact do affect, fundamental choices made by ERISA plan administrators; they substantially increase the costs imposed on ERISA plans; and they directly undermine Congress's goal of regulatory uniformity in the administration of ERISA plans.

A. Any State Law -- Including A "Law Of General Applicability" -- Is Preempted If It "Relates To" An ERISA Plan.

Petitioners' entire argument rests upon their attempt to manufacture a distinct ERISA preemption standard applicable to "laws of general applicability." See, *e.g.*, N.Y. Br. 13-18; Blues Br. 18-27; U.S. Br. 10-18. In petitioners' view, such measures are rarely, if ever, preempted because they virtually never have a sufficient impact on ERISA plans. See, *e.g.*, N.Y. Br. 15-17. This Court has repeatedly rejected this contention.

To begin with, there is no doubt that generally applicable laws fall within Section 514(a). That provision by its terms reaches "any and all State laws." Indeed, as this Court has observed, the statutory exemptions from preemption for laws "regulat[ing] insurance, banking, or securities" (Section 514(b)(2)(A); 29 U.S.C. § 1144(b)(2)(A)) and for "any generally applicable criminal law of a State" (Section 514(b)(4); 29 U.S.C. § 1144(b)(4)) "would have been unnecessary * * * if § 514(a) applied only to state laws dealing specifically with ERISA plans." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983).[7]

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[7] Furthermore, Section 514(a) preempts state laws only "insofar as they * * * relate to" plans, instead of fully superseding all state laws "that relate" to plans. The effect of that language is to preserve generally applicable laws to the extent they do *not* relate to ERISA plans. If Section

(Footnote continued)

Given this explicit statutory language, it is not surprising that the Court consistently has recognized that "a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand*, 498 U.S. at 139. Accord *FMC*, 498 U.S. at 58-59; *Metropolitan Life*, 481 U.S. at 62; *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 463 U.S. at 98; *Alessi*, 451 U.S. at 504 ("ERISA makes clear that even indirect state action bearing on" ERISA plans "may encroach upon the area of exclusive federal concern"). See also *Morales*, 112 S. Ct. at 2038 (holding that the identical preemption provision of the Airline Deregulation Act extends to generally applicable laws on the ground that a narrow interpretation of the provision would "creat[e] an utterly irrational loophole").

To be sure, the preemption analysis is easiest with respect to state laws that affect only ERISA plans. It is a simple matter to conclude that such measures "relate to" ERISA plans and are therefore preempted by Section 514(a). But that does not mean that more general laws are immune from preemption. To the contrary, this Court frequently has found such statutes preempted. See, *e.g.*, *FMC* (ERISA preempts Pennsylvania anti-subrogation statute); *Ingersoll-Rand* (ERISA preempts Texas common-law cause of action for wrongful discharge, as applied to claim that employee was discharged to prevent his recovery of plan benefits); *Pilot Life* (ERISA preempts Mississippi common-law tort and contract causes of action asserting improper processing of claims for benefits under insured plan); *Shaw* (ERISA preempts New York civil rights law).

The Court also has recognized, however, that Section 514(a) does not preempt every state law of general

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514(a) did not reach such laws, this limitation on the provision's preemptive effect would be unnecessary.

applicability that in any way affects an ERISA plan. ERISA leaves in place laws that have only a "tenuous, remote, or peripheral" impact on covered plans. See *Shaw*, 463 U.S. at 100 n.21. That category is narrow, however: in only one case -- *Mackey* v. *Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988) -- did the Court hold that the statute (there, a garnishment law applicable to all business entities) was not preempted. See *infra* pp. 20-21. The Court has indicated, in dicta, that "lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" also may withstand preemption. *Mackey*, 486 U.S. at 833.

Thus, the question before the Court is not -- as petitioners would have it -- a novel issue regarding the status under ERISA of state laws of general applicability. It is the very same issue the Court confronted in *FMC*, *Pilot Life*, *Mackey*, *Metropolitan Life*, and *Ingersoll-Rand*: whether the challenged state law's undisputed effect on benefit plans is "too tenuous, remote, or peripheral" to satisfy the statutory standard. In addition, the Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.' " *Greater Washington Board of Trade*, 113 S. Ct. at 583. See also *Ingersoll-Rand*, 498 U.S. at 139; *FMC*, 498 U.S. at 58; *Pilot Life*, 481 U.S. at 47; *Metropolitan Life*, 471 U.S. at 739. The surcharge laws are preempted under both of those tests.

B. The Surcharge Laws Have A "Connection With" ERISA Plans.

Petitioners try to create the impression that the sole argument in favor of preemption is that the surcharge laws increase the costs of ERISA plans. *E.g.*, U.S. Br. 10-18; HANYS Br. 17. It is of course true that these laws add dramatically to the costs of running ERISA plans in the State of New York -- an increase of hundreds of millions of dollars

annually. J.A. 303, 310, 327. But the effect of the surcharges on ERISA plans goes far beyond that concern. First, the laws were enacted for the specific purpose, and have the undeniable effect, of influencing fundamental decisions by ERISA plan administrators. Second, the surcharges have the effect of eliminating uniform administration of ERISA plans -- precisely the result that Congress sought to avoid in enacting the broad preemption provision. These factors establish beyond doubt the surcharges' "connection with" ERISA plans.

1. The Surcharge Laws Were Designed To Affect, And Do Affect, ERISA Plans' Choices Regarding The Method Of Providing Health Care Benefits.

As we have discussed (see *supra* pp. 6-9), the very purpose and effect of the challenged surcharges is to manipulate the selection by employee benefit plans of the most efficient arrangement for payment of health care benefits. Every choice other than the Blues is burdened by a severe financial penalty:

- if a plan chooses to self-insure, Section 2807-c operates to raise hospital reimbursement rates by 13%;
- if a plan chooses a commercial insurer, Section 348 of the Omnibus Act imposes a 24% surcharge;
- if a plan contracts with an HMO, its rates will rise as a result of the 9% HMO surcharge.

ERISA plans comprise the overwhelming majority of the customers of health care benefit payors in New York. See *supra* p. 1. When a plan sponsor considers what form of health care coverage to furnish plan participants and beneficiaries, these surcharges cannot be ignored, because cost of coverage is one of the primary considerations driving a plan sponsor's choice. J.A. 134-35. The surcharges thus have the inexorable effect of tilting ERISA plans away from

the disfavored benefit payors and toward the Blues. As the court of appeals found (Pet. App. A22):

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage.

Petitioners themselves acknowledge that the 13% and 11% surcharges were designed to make self-insurance and commercial insurance less attractive to purchasers of health care coverage in New York. Thus, the Blues frankly admit that a principal purpose of the 24% surcharge was to make purchasers of health insurance "think twice as hard" about using a commercial insurer. J.A. 207, 217-18. HANYS agrees (Br. 34) that the surcharges "might influence consumers (including ERISA plans) to elect Blue Cross coverage," and concedes that the court of appeals' finding that the surcharges "purposely interfere" with the choices made by ERISA plans is correct "[t]o some degree."

This undisputed effect establishes the surcharges' "connection with" ERISA plans. The very purpose of an employee welfare benefit plan is to "provid[e] for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits, or benefits in the event of sickness [or] accident * * *." 29 U.S.C. § 1002(1). Obviously, determining how those benefits will be provided -- whether "through the purchase of insurance or otherwise" and, if through the

purchase of insurance, selecting the type of insurance -- lies at the very heart of the administration of the plan.

Unlike a bridge toll or other state law that merely affects an ERISA plan's cost of doing business, like every other business, the surcharge laws intentionally interfere with an ERISA welfare plan's most basic administrative decision: how best to provide plan members with health care coverage. Because the surcharge laws were designed with precisely this purpose in mind, it is simply absurd to argue that they have a mere "remote, tenuous or peripheral" effect on ERISA plans. Rather, it is difficult to imagine a closer (or more disruptive) connection between a state statute and an ERISA plan.[8]

This Court has already determined that state laws that interfere with plan choices trigger ERISA preemption. *Metropolitan Life*, for example, involved a state law requiring plans "to purchase the mental health benefits specified in the statute when they purchase a certain kind of common insurance policy." 471 U.S. at 739. By tying a means of providing benefits to a particular type of benefit, the statute infringed the freedom of ERISA plans to decide for themselves how to provide benefits: a plan that wished to use insurance was forced to purchase mental health benefits. Massachusetts conceded, and this Court squarely held, that the measure was "relate[d] to" ERISA plans within the meaning of Section 514(a).

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[8] Petitioner HANYS argues (Br. 35) that the differential should not be preempted because it is "difficult to see why Congress would regard the existence of [a choice of lower rates] as an evil to be foreclosed * * * ." But this Court had no difficulty enforcing ERISA's broad preemption provision to displace an antidiscrimination provision in New York's Human Rights Law (see *Shaw*, *supra*) "even though Congress had not expressed any intent in ERISA to approve of the employment practices that the State had banned by its statute." *Mackey*, 486 U.S. at 830. In short, "[l]egislative 'good intentions' do not save a state law within the broad pre-emptive scope of § 514(a)." *Id.* Here, moreover, the very legislative purpose is to skew the choices facing ERISA plans.

The surcharges at issue here have precisely the same effect: they intentionally infringe plans' freedom to decide how to provide benefits by increasing the cost of every choice other than the Blues. "Congress vested plan sponsors with discretion to determine whether to fund benefits 'through the purchase of insurance or otherwise.' " Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 TEX. L. REV. 1313, 1336-37 (1984). State interference with this "federally mandated discretion" is preempted. *Id.*

The federal government agreed with this analysis in the court of appeals. Although it has now reversed position (without explaining why), and advances an argument squarely inconsistent with many of its prior submissions to this Court,[9] the government's former comments succinctly summarize the surcharges' impermissible effect:

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[9] Indeed, the government's position in this case is a radical departure from its traditionally broad interpretation of Section 514(a). In its brief in *Pilot Life*, for example, the government argued in favor of preemption of a state law of general applicability on the ground that it tended to "make funding welfare plans by purchasing insurance relatively expensive compared with self-insuring." Br. 8. The government "doubt[ed] that Congress intended to create this more substantial incentive to self-insure since employees' benefits may be better protected by insured plans." *Ibid.* Here, of course, the government contends that a virtually identical effect does not trigger the protections of Section 514(a).

Moreover, in contrast to its argument here that the phrase "relate to" must be read narrowly in order to save state laws with indirect economic effects on ERISA plans, the government in the past has argued consistently that the phrase "relate to" must be read broadly. See, *e.g.*, U.S. Br. 10-12 & n.4, *Greater Washington Board of Trade*, 113 S. Ct. 580 (No. 91-1326) ("it is no longer open to question whether Section 514(a) has as broad a sweep as its dictionary definition suggests"); U.S. Br. 11, *Ingersoll-Rand*, 498 U.S. 133 (No. 89-1298); U.S. Br. 8-9, *Mackey*, 486 U.S. 825 (No. 86-1387); U.S. Br. 11, *Ft. Halifax Packing Co.* v. *Coyne*, 482 U.S. 1 (1987) (No. 86-341) ("This Court has concluded that 'relates to' in Section 514(a) must be read broadly, as the normal meaning of the phrase suggests * * * ."); U.S. Br. 24-26, *Alessi*, 451 U.S. 504 (No. 79-1943).

> [T]he surcharges have a "connection with" plans, for their intent and effect is to alter plan behavior. The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% charges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge. *Shaw, Metropolitan [Life]* v. *Massachusetts* and *General Electric* v. *New York Dep't of Labor* all hold that such changes in plan structure and benefit levels constitute the requisite "connection" for purposes of § 514.

Gov't C.A. Br. 19-20.

In contending nonetheless that the surcharge laws do not "relate to" ERISA plans, petitioners assert (HANYS Br. 17) that *Mackey* is the case "most closely analogous" to this one. Because the Court rejected the claim of preemption in *Mackey*, petitioners argue, it should reach the same conclusion here. That assertion misunderstands both the decision in *Mackey* and the fatal flaw in the surcharge laws.

The Court did not hold in *Mackey* that state laws that increase the costs borne by ERISA plans are never preempted. The question in *Mackey* was whether an ERISA plan could be subjected to a garnishment action. Although the argument in favor of preemption rested in part on the "substantial administrative burdens and costs" imposed upon the plan by the garnishment process (486 U.S. at 831), the Court's analysis turned entirely on the detailed civil enforcement scheme set forth in ERISA itself.

The Court found that Congress clearly contemplated that ERISA plans could be sued, and money judgments awarded against them. 486 U.S. at 832-33. In certain types of civil

actions,[10] however, ERISA does not provide an enforcement mechanism for collecting such judgments. The Federal Rules of Civil Procedure, applicable in this context, defer to state collection methods, and the Court therefore concluded that these state laws were not preempted: "otherwise, there would be no way to enforce such a judgment won against an ERISA plan." *Id.* at 834. Because garnishment is simply a permissible method of collecting a money judgment, the Court refused to find it preempted for the same reason. In addition, the Court observed that ERISA contains an express anti-assignment provision that does not apply to garnishment. In sum, the result in *Mackey* was based upon the literal language of ERISA, which makes clear that the preemption provision does not reach garnishment proceedings.

Even if *Mackey* did rest on a conclusion that the monetary and administrative burdens imposed upon the plan by garnishment were too "remote, tenuous or peripheral" to trigger preemption -- something that seems improbable in view of the fact that garnishment has the quite direct effect of barring a plan from paying benefits to a beneficiary -- that conclusion would be inapplicable to the massive surcharges at issue here. Unlike a state law applicable to business entities generally (*e.g.*, a property tax or minimum wage law, which increases plan costs in a nondiscriminatory manner), the surcharge laws *purposefully discriminate among benefit payors* in order to influence the choices made by ERISA plans. That direct, and intentional, interference with plans' freedom of choice plainly establishes the requisite "connection" between the state laws and ERISA plans.[11]

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[10] That is, so-called "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan." *Mackey*, 486 U.S. at 833.

[11] Petitioners rely (*e.g.*, Blues Br. 15, 23-27) on *United Wire, Metal & Machine Health & Welfare Fund* v. *Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993). But the Third

(Footnote continued)

2. *The Surcharge Laws Obstruct Congress's Goal Of Regulatory Uniformity By Producing State-Created Differences Among Benefit Payors That Impel Sponsors Of Multi-State ERISA Plans To Tailor Their Conduct To New York Law.*

There is a second, and equally powerful, reason why the New York laws have a "connection with" ERISA plans: they directly contravene the congressional purposes of establishing uniform federal regulation of ERISA plans and avoiding the conflicts and administrative inefficiencies that would invariably result if employers were required to "tailor[]" their plans to the "peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. See also *FMC*, 498 U.S. at 60 ("[t]o require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits"); *Shaw*, 463 U.S. at 105 ("[b]y establishing benefit plan regulation 'as exclusively a federal concern,' * * * Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees").

The surcharge laws have the precise effect that Congress sought to prevent. Many of the plans affected by the surcharge laws are multi-state plans covering employees located in states other than New York. J.A. 117-21, 125-26, 129-30, 133-34, 136-37, 139-40, 141-42, 144-45. These plans frequently prefer to deal with a single nationwide benefit payor in order to standardize procedures and thereby reduce

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Circuit acknowledged that a law relates to an ERISA plan if it is "specifically designed to affect employee benefit plans" (*id.* at 1192); there simply was no evidence that the challenged New Jersey law was designed to influence ERISA plan choice regarding particular forms of health coverage. Here, of course, that was the conceded purpose of the surcharge laws.

administrative costs. In addition, multi-state plans can use their buying power in the national insurance market to obtain better terms from benefit payors.

The state-created cost differential, however, puts a plan in the position of choosing between incurring higher benefit payor costs (by selecting a New York benefit payor other than the Blues) or higher administrative costs (by selecting the Blues in New York and another benefit payor for the rest of the country). And if New York is free to tilt plan choice toward a favored benefit payor in this manner, other states may do so as well. Parochial preferences established by various states could have the practical effect of forcing plans to forgo entirely the option of a nationwide plan in favor of choices dictated by these state preferences. Allowing states to alter the relative costs of different types of benefit payors would thus require plans to "tailor[]" their plans to the "peculiarities of the law of each jurisdiction," thereby thwarting Congress's goal of nationwide uniformity.

Petitioners' only response is to point out that hospital costs would vary from region to region with or without regulation. See, *e.g.*, N.Y. Br. 22-23; Blues Br. 21-22. But the fact that costs may vary from place to place because of market factors does not give a state license to step in and artificially alter the relative costs of different types of benefit payors. The surcharges are designed to -- and do -- produce *state-created* disuniformity that burdens multi-state plans' attempts to take advantage of the efficiencies of the national market. Under the Court's precedents, that burden constitutes a "connection with" covered plans sufficient to trigger ERISA preemption. See *FMC*, 498 U.S. at 58-59; *Alessi*, 451 U.S. at 524-25.

3. The Surcharges Are Not Immune From Preemption Because They Affect Plans Through Economic Incentives Rather Than Direct Regulation.

Petitioners do not dispute that a New York law would be preempted if, for example, it required ERISA plans to use the

Blues to provide health insurance. The crux of their submission is that "[t]here is a legally significant distinction between influencing plan choice and mandating plan conduct." N.Y. Br. 27. That assertion defies both common sense and this Court's precedents.

Petitioners concede that the surcharges were designed to influence plan choice in determining whether to provide plan members with health care coverage through self-insurance, an HMO, commercial insurance or Blue Cross coverage. But what if the 24% differential were not enough to "influence choice" to a degree that the Blues' competitive position improved? If the State were to respond with a 100% or a 1000% surcharge, could one still say that it was merely "influencing choice" as opposed to "mandating conduct?"

Petitioners' position, if accepted by this Court, would gut ERISA's preemption provision by allowing states to use draconian penalties to do indirectly -- control the decisions of ERISA plans -- precisely what they may not do through direct regulation. Indeed, given petitioners' view, Massachusetts could have avoided the "connection" ruling in *Metropolitan Life* if, instead of requiring that plans using insurance provide mental health benefits, it simply had imposed a substantial surcharge on insurance policies that omitted mental health benefits.[12]

Such sterile formalism simply makes no sense. As this Court has recognized, "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision." *Alessi*, 451 U.S. at 525. Petitioners' approach would instead elevate form over substance.

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[12] Petitioner HANYS attempts to distinguish *Metropolitan Life* on the ground that it left plans "*without* a choice." Br. 36 (emphasis in original). In fact, although Massachusetts did not use financial incentives to influence plan conduct, it did leave plans a choice: the purchase of mental health benefits was mandatory only if a plan "purchase[d] a certain kind of common insurance policy." 471 U.S. at 739. Thus, ERISA plans operating in Massachusetts could have avoided the law by self-insuring.

In other areas of the law, the Court has not distinguished between monetary levies and direct regulation, recognizing that the former may have precisely the same practical effect as the latter. Thus, the Court has acknowledged that state tort rules -- which simply impose monetary burdens -- have the same practical effect as state regulations for purposes of preemption. See, *e.g.*, *Cipollone*, 112 S. Ct. at 2620. And taxes can run afoul of constitutional limits on state authority, such as the First Amendment and the Commerce Clause, even though they only "influence choice" and do not "mandate conduct."

In sum, the surcharge laws have the purpose and effect of driving the sponsors or administrators of ERISA plans operating in New York to provide plan members with their health coverage through the Blues rather than commercial insurance or self-insurance. This blatant interference with the administration and structure of ERISA plans and the plan sponsors' strategy concerning the most effective method of providing benefits constitutes a sufficient "connection with" ERISA plans to warrant preemption.

Finally, unable to defend the New York statutes on any other ground, petitioners and their amici rely on a lengthy parade of horribles in arguing that affirmance of the decision below will automatically lead to preemption of numerous generally applicable state laws with indirect economic impacts on ERISA plans as well as virtually all state health care regulation. These predictions are demonstrably false.

What is at issue here is a state's ability to pass laws intended to influence what is probably an ERISA welfare plan's most fundamental administrative determination: how best to provide plan members with health care coverage. None of the other regulations cited by the State or its amici comes close to having that kind of manipulative effect.

Indeed, we know of no other state law that is specifically designed to force ERISA plans to the state's favored health

insurer. Thus, twelve states appearing as amici curiae observe that "hospital rate-setting programs across the country differ significantly from the New York surcharges, and * * * many states are engaging in other forms of properly authorized health care-related activities on behalf of their citizens." States Br. 28. These states recognize that the Court can rule narrowly here, urging the Court to base its decision on "the characteristics presented solely by the New York system." *Ibid.* (footnote omitted).

This case simply does not require the Court to decide whether a state law that produces an across-the-board increase in the cost of medical services -- and that is not crafted with the purpose and effect of influencing fundamental ERISA plan choices -- is preempted because it has an indirect economic impact on ERISA plans. The Court "need not determine the outer bounds of ERISA's pre-emptive language to find this [New York] provision an impermissible intrusion on the federal regulatory scheme." *Alessi*, 451 U.S. at 525.[13]

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[13] Petitioners and their amici cite *NYSA-ILA Medical and Clinical Services Fund* v. *Axelrod*, 27 F.3d 823 (2d Cir. 1994), petition for cert. filed, 63 U.S.L.W. 3371 (U.S. Oct. 21, 1994) (No. 94-745), and *New England Health Care Employees' Union, District 1199* v. *Mt. Sinai Hosp.*, 846 F. Supp. 190 (D. Conn. 1994), app. pending, Nos. 94-7264, 94-7906 (2d Cir.), as purported examples of how the instant case will lead to the demise of hospital rate regulation and regulation in the health care area generally. See, *e.g.*, Blues Br. 22-23 n.19 (citing the foregoing cases as examples of challenges to hospital and insurance regulations premised on the "irrational ramifications" of the court of appeals' ruling in this case). These cases, however, present fact situations entirely different from the one at bar. *NYSA-ILA* involved a direct tax on ERISA plan contributions and payments intended to pay for participants' medical benefits. *New England Health Care* involved a challenge to Connecticut's Uncompensated Care Pool Act. New York has an uncompensated care provision in its hospital rate structure, but this case does not challenge it. These entirely different issues can and will be addressed on the basis of the records compiled in those cases.

C. The Surcharge Laws "Refer to" Self-Insured ERISA Plans.

The 13% surcharge, in addition to suffering from the infirmities discussed above, is preempted for the further reason that it refers expressly to self-insured ERISA plans. Section 2807-c(1)(b) imposes the 13% surcharge on the hospital bills of patients "enrolled in a self-insured fund * * *." Pet. App. A102. Under this Court's precedents, that reference is sufficient to invoke preemption under Section 514(a).

The Court has held that "any state law imposing requirements by reference to [ERISA plans] must yield to ERISA." *Greater Washington Board of Trade*, 113 S. Ct. at 582-83 (footnote omitted). Accord *Mackey*, 486 U.S. at 838 n.12. It is true that the New York Legislature did not use the phrase "ERISA plans" or "employee welfare benefit plans" in Section 2807-c(1)(b). But that does not preclude preemption. In *FMC*, the Court found preempted a Pennsylvania law that referred to "[a]ny program, group contract or other arrangement for payment of benefits," even though the statute did not explicitly refer to "ERISA plans" or "employee welfare benefit plans subject to ERISA." 498 U.S. at 59. Because the Pennsylvania statute obviously encompassed ERISA plans, it "ha[d] a 'reference' to" those plans within the meaning of ERISA's preemption clause. *Ibid.*

More recently, in *Greater Washington Board of Trade*, the Court held preempted a District of Columbia workers' compensation statute that provided:

> Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter.

113 S. Ct. at 582 (quoting D.C. Code Ann. § 36-307(a-1)(1)). The Court found that this statute specifically referred to

ERISA plans "and on that basis alone is pre-empted." *Ibid.* Under *FMC* and *Greater Washington Board of Trade*, the conclusion is inescapable that Section 2807-c(1)(b), as applied to self-insured funds, "refers to" ERISA plans and is preempted.

D. This Court Should Reject Petitioners' Invitations To Rewrite Section 514(a).

Apparently recognizing that the surcharge laws fit squarely within the language of Section 514(a) as construed in this Court's precedents, petitioners urge the Court to narrow the scope of that provision. These pleas for relief, which rest principally on policy grounds, should be addressed to Congress. They provide no reason for this Court to overturn its prior decisions.[14]

First, petitioner HANYS argues (Br. 19-23) that there is no evidence that Congress intended to enact a preemption provision broad enough to encompass the surcharge laws. As the Court has repeatedly observed (see *supra* p. 12 & n.6), however, the broad statutory language is the best evidence of Congress's intent. The legislative history also makes clear that Congress knew just what it was doing. The preemption provision that became Section 514(a) was added in the Conference Committee. H.R. Conf. Rep. No. 1280, 93d

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[14] Indeed, we note that Congress has continued to scrutinize the impact of the ERISA preemption provision on health care reform efforts at the state level. See, *e.g.*, S. 3180, 102d Cong., 2d Sess. (1992) (bill establishing a federal commission to grant limited waivers from Section 514(a) to states that enacted comprehensive health care reform laws); S. 2452, 103d Cong., 2d Sess. (1994) (bill that would amend ERISA to "provide the states with the flexibility to continue their reform efforts"). A House committee held hearings on this subject as recently as November 30, 1994. See 1994 Daily Labor Report, *Current Developments* d12 (Dec. 1, 1994). The fact that Congress has focused on this question diminishes even further petitioners' argument that this Court should alter its long-standing construction of Section 514(a) in order to achieve allegedly beneficial policy goals.

Cong., 2d Sess. 82 (1974), *reprinted in* 3 Senate Committee on Labor and Public Welfare, Legislative History of the Employee Retirement Income Security Act of 1974, at 4357 (Committee Print 1976) (Legislative History). That Committee also included in the bill a provision creating a Joint Pension Task Force (Task Force). The Task Force was directed to make a "full study and review" of various topics and present a report to Congress. One of those topics was "the effects and desirability of the Federal preemption of State and local law with respect to matters relating to pension and similar plans." 3 Legislative History at 4476.

Congress was well aware that it was taking a bold step when it amended ERISA's preemption provision to sweep aside all state laws "relat[ing] to" employee benefit plans: the conferees explicitly stated that they "recogniz[ed] the dimensions of such a policy." *Id.* at 4771. That undoubtedly is why the Task Force was assigned the job of studying preemption. "If it is determined," the conferees noted, "that the preemption policy devised has the effect of precluding essential legislation at either the State or federal level, appropriate modifications can be made." *Ibid.* The Court has observed that "the [Task Force] Report expressed approval of ERISA's broad pre-emption of state law, explaining that 'the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Shaw*, 463 U.S. at 99 n.20 (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977)). Indeed, "[t]he Report recommended only that the exceptions described in § 514(b) *be narrowed still further*." *Ibid.* (emphasis added).[15]

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[15] Petitioner HANYS rummages (Br. 20-23) through ERISA's legislative history in search of evidence that Congress did not intend to preempt state laws like the surcharges. First, HANYS asserts (Br. 21) that "the Conference Report referred to state laws directly pertaining to employee benefit plans," such as disclosure and fiduciary requirements, in providing examples of preempted laws. But, as we have discussed (see *supra* p. 14),

(Footnote continued)

Petitioners also urge the Court to recognize a "health care law" exception to Section 514(a). Specifically, petitioner HANYS pieces together (Br. 29-33) various bits of congressional action relating to the Medicare and Medicaid programs in an effort to show that Congress could not have intended ERISA's preemption clause to supersede state laws regulating hospital costs or health care.

This contention has an Alice-in-Wonderland quality. A principal purpose of employee welfare benefit plans is to furnish health care for plan participants and their beneficiaries. In view of the fact that covered plans furnish health care benefits, Congress must have understood that many state health care laws would "relate to" covered plans. If Congress

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this Court has concluded that the preemption provision reaches laws with an indirect but nonetheless real effect on ERISA plans. Indeed, "to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history" because the limited preemption clauses contained in earlier versions of the bill "were rejected in favor of the present language in the Act, 'indicat[ing] that the section's pre-emptive scope was as broad as its language.' " *FMC*, 498 U.S. at 58-59 (footnote omitted) (quoting *Shaw*, 463 U.S. at 98).

Next, HANYS seizes (Br. 21) on Rep. Dent's reference to the Health Maintenance Organization Act and cites that as a basis for limiting the preemptive reach of ERISA. But HANYS conveniently ignores Rep. Dent's statement -- made practically in the same breath -- that "the provisions of section 514 would reach any rule, regulation, practice or decision of any State, subdivision thereof or any agency or instrumentality thereof -- including any professional society or association operating under code of law -- *which would affect any employee benefit plan*." 3 Legislative History at 4670-71 (emphasis added). Thus, the snippet of legislative history that HANYS highlights to "confirm" its position on ERISA preemption actually contradicts it. The second problem with HANYS's point is that the HMO Act's painstaking recitation of the types of state laws intended to be displaced shows (just like ERISA's doomed predecessor bills) that Congress knew how to craft a limited preemption provision when it wanted to do so. In the case of ERISA, however, it deliberately chose to do the opposite.

meant to reserve health care laws exclusively to state concern, it surely would have included that category of laws in the savings clause, along with laws regulating insurance, banking and securities. Because Congress did not take that step, the status of health care laws must be evaluated, like other state laws, on a case-by-case basis. Some are preempted; others are not.

This point is made clear by the Court's summary affirmance in *Agsalud* v. *Standard Oil Co.*, 454 U.S. 801 (1981). In that case, the State of Hawaii passed the "Hawaii Prepaid Health Care Act," which required workers in the state "to be covered by a comprehensive prepaid health care plan." *Standard Oil Co.* v. *Agsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), aff'd, 633 F.2d 760 (9th Cir. 1980), aff'd, 454 U.S. 801 (1981). Standard Oil challenged the Hawaii law on the ground that it was preempted by ERISA. The district court noted that ERISA's legislative history "contains no unambiguous evidence that Congress did not intend to preempt [health insurance laws]." 442 F. Supp. at 706. The court found that the only "sure guide" to Congress's intent is the language used in the preemption provision, "and that language clearly means that ERISA preempts state health insurance laws." *Ibid.* The Ninth Circuit and this Court, in turn, affirmed.

Congress's reaction to the *Standard Oil* decision is highly significant. It did not amend ERISA's preemption clause to change the "relate to" standard, and it did not amend ERISA's savings clause to carve out all health care laws. Rather, Congress exempted only the Hawaii Prepaid Health Care Act. See 29 U.S.C. § 1144(b)(5)(B)(ii) (1988).[16] That course of action provides further evidence that laws operating in the

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[16] In granting this exemption from Section 514(a), Congress made clear its limited scope. Any amendments to the Hawaii statute after September 2, 1974, are not exempt from preemption. *Id.* Furthermore, the exemption "shall not be considered a precedent with respect to extending such amendment to any other State law." Pub. L. No. 97-473, § 301(b), 96 Stat. 2605, 2612 (1983).

health care or health insurance fields do not enjoy any special immunity from ERISA's preemption provision.

II. THE SURCHARGE LAWS ARE NOT SAVED FROM PREEMPTION BECAUSE THEY DO NOT "REGULATE[] INSURANCE."

As discussed in Part I, petitioners ask this Court to rewrite Section 514(a) to preempt only those state laws that mandate "requirements" for ERISA plans, rather than "any and all State laws [that] relate to" plans. Similarly, petitioners ask this Court to revise and expand Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), the clause that saves from preemption only those state laws that "regulate[] insurance." As we explain below, this aspect of petitioners' argument is equally foreclosed by the statutory language and the decisions of this Court.

Petitioners candidly acknowledge that the 13% and 11% surcharges were designed to influence ERISA plans' choices of health care coverage (HANYS Br. 40-41); for that very reason, petitioners contend that the surcharges "regulate[] insurance."[17] The accuracy of petitioners' concession, however, does not transform the surcharge law into a *regulation of insurance*.

Petitioners seem to recognize that the language of the savings clause is difficult to square with their argument. As a consequence, they insist that the clause saves all state laws that "relate to" or "affect" insurance.[18] But that is not what the

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[17] Petitioners do not argue that the 9% surcharge is saved from preemption as a law regulating insurance, and for good reason: New York -- which enforces the statute -- frankly concedes (Br. 30 n.22) that the 9% surcharge "regulates HMOs as providers of managed medical care, not as insurers."

[18] See, *e.g.*, Blues Br. 35 (surcharges are saved because they are "designed to affect" insurance); *id.* at 37 ("affected"); *id.* at 38 ("affect" insurance relationship); N.Y. Br. 31 (surcharges are "connected to a payor's status in the insurance marketplace"); HANYS Br. 37 *et seq.* (explicitly equating "relate to" with "regulates"); *id.* at 40 (equating "affect" with "regulate").

statute says: the savings clause does not sweep in every state law that "ha[s] an impact on the insurance industry." *Pilot Life*, 481 U.S. at 50. On the contrary, the clause merely "protect[s] state insurance regulation of insurance contracts purchased by employee benefit plans." *FMC*, 498 U.S. at 64; see *id.* at 62-63.

The power that is saved from ERISA preemption -- like that preserved in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* -- extends only to state regulation of the policy relationship between the insurer and the insured. *Metropolitan Life*, 471 U.S. at 740. The surcharge laws, however, have nothing to do with the policy relationship, but rather regulate hospital rates in an attempt to force ERISA plans to provide health benefits through the Blues. As such, the surcharges do not "regulate[] insurance" under the analysis that this Court consistently has applied, and therefore are not saved from preemption.

A. The Surcharges Do Not "Regulate[] Insurance" Under The Analysis Consistently Applied By This Court.

To determine whether a law comes within the ERISA savings clause, this Court first considers whether the state law "regulates insurance" under the common-sense meaning of those terms. *Pilot Life*, 481 U.S. at 48. Then, the Court pursues a three-part inquiry developed to interpret the "similarly worded protection" afforded by the McCarran-Ferguson Act. *Ibid.* See *Metropolitan Life*, 471 U.S. at 743-44 & n.21. The Court examines,

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Id. at 743 (citing *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119, 129 (1982), and *Group Life & Health Insurance*

Co. v. *Royal Drug Co.*, 440 U.S. 205 (1979)) (emphasis in original).[19] Under these controlling standards, the hospital surcharges do not regulate insurance.

1. The Surcharges Do Not "Regulate[] Insurance" Under A "Common-Sense View."

The threshold inquiry under the ERISA saving clause is whether a statute regulates insurance under a common-sense view of the matter. *Metropolitan Life*, 471 U.S. at 739-40. Applying common sense, it is evident that New York's unique surcharge laws bear no resemblance to traditional insurance regulation. Indeed, New York -- the regulating authority -- admitted in the Second Circuit that the 13% surcharge did not regulate insurance. N.Y. C.A. Br. 33 n.42. Although the State resists that logical conclusion here, it nevertheless forthrightly concedes that the surcharge law is a "hospital rate-setting statute," not an insurance regulation. N.Y. Br. 31; see also, *e.g.*, *id.* at 4, 16; *id.* at 9-11 *et passim* (surcharges are "health care assessments"); N.Y. C.A. Br. 22 (surcharge "statute regulates only the cost of hospital care services, requiring hospitals to bill patients at certain rates"); *id.* at 33 n.42.

This Court's precedents reinforce this common-sense conclusion. Recently the Court reconfirmed that the regulation of insurance focuses on the contractual "relationship between the insurance company and its policyholders." *Fabe*, 113 S. Ct. at 2208.[20] See *Metropolitan Life*, 471 U.S. at 740 (a

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[19] The government is mistaken in suggesting (Br. 20) that only a "common-sense" assessment is necessary. In the sole case cited to support that claim, the parties *did not contest* the application of the savings clause. *FMC*, 498 U.S. at 60. Moreover, although this Court stated in passing that none of the three McCarran-Ferguson factors "is *necessarily* determinative in itself," *Pireno*, 458 U.S. at 129, each statute or practice that the Court has held to be within the "business of insurance" in fact satisfied all three criteria. See, *e.g.*, *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202, 2209 (1993); *Metropolitan Life*, 471 U.S. at 743.

[20] Even a law that is specifically directed at the insurance industry does not always "regulate" insurance. See, *e.g.*, *Fabe*, 113 S. Ct. at 2202

(Footnote continued)

mandated-benefits law that "regulates the terms of certain insurance contracts" is saved); *Pilot Life*, 481 U.S. at 51 (a common-law cause of action that "does not define the terms of the relationship between the insurer and the insured" is not saved); *FMC*, 498 U.S. at 61 (an anti-subrogation law that "directly controls the terms of insurance contracts" is saved). The relationship between an insurer and a hospital or other service provider is "wholly separate" from the relationship between an insurer and its insured. *Royal Drug*, 440 U.S. at 216 n.14; see *Fabe*, 113 S. Ct. at 2212. It is "next to impossible to assume that Congress could have thought" that the "purchase" by insurance companies "of goods and services from third parties" is "insurance," or that an unusual law that prescribes or regulates payments to those third parties "regulates insurance." *Royal Drug*, 440 U.S. at 230.

Regulatory provisions that address "the relationship between insurer and insured" include controls over "the type of policy" that can be issued, "its reliability, its interpretation, and [its] enforcement." *Metropolitan Life*, 471 U.S. at 743-44. In short, for the purpose of the savings clause, state laws that "regulate insurance" govern the formation, terms, and performance of the insurance contract. To ensure the integrity of contract formation and performance, that regulation may address the financial management of an insurance company, and the sale and advertising of insurance. See *id.* at 728.

Although New York's Insurance Law contains many such regulations, the surcharge laws are of another ilk. They do *not* impose *any* requirement on insurance companies or establish *any* of the terms of insurance contracts. Instead, they simply dictate the rates that a hospital must charge a patient, penalizing consumers and ERISA plans that use disfavored

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(although the challenged law at issue applied only to insurance companies, it regulated insurance only to extent it governed the insurer-policyholder relationship); *National Securities, Inc.* v. *SEC*, 393 U.S. 453 (1969) (laws regulating insurance company mergers did not regulate insurance).

methods to provide for their medical expenses. Although the surcharges may lend support to a politically favored participant in New York's insurance marketplace, that market distortion does not transform the surcharge laws into "regulations of insurance." See *Pilot Life*, 481 U.S. at 50.

For a related reason, there is no merit to the government's suggestion (Br. 24) that the surcharges are saved because they are "designed to affect the calculation of insurance rates by reducing the cost differential that existed between the Blues and the other insurers." Until this case, the government consistently recognized that a State's attempt to reduce insurers' costs was *not* a regulation of insurance. U.S. Br. 20, *Fabe* (No. 91-1513); see also U.S. Br. 14 n.14, *Pireno* (No. 81-389); U.S. Br. 30, *Royal Drug* (No. 77-952). A surcharge on the rates that hospitals charge patients does not "regulate insurance," regardless of its effect on insurers' costs. Although the law will make commercial insurance more expensive and therefore may lead insureds to seek other coverage, that indirect consequence does not "regulate" insurance in any common-sense way. See *Fabe*, 113 S. Ct. at 2212.

Rather than confront the statutory requirement that state laws actually "regulate insurance" in order to be saved from ERISA preemption, petitioners seek to turn Section 514 on its head, confusing the breadth of the preemption provision with the narrow scope of the savings clause. Having argued that only state laws that single out and directly *regulate* ERISA plans *"relate to"* plans for the purposes of the preemption clause, petitioners and the United States now insist that any state law that *relates to* the insurance market "*regulates* insurance" and therefore is saved from preemption. See, *e.g.*, HANYS Br. 37 *et seq.* (arguing that all laws that "relate to" insurance therefore "regulate" it). Indeed, the government suggests that it is enough that the surcharge laws are "related to traditional objectives of insurance regulation, such as risk spreading, regulating rates, and ensuring solvency of

insurers." U.S. Br. 23 (footnotes omitted).[21] As this phrasing implicitly concedes, however, the hospital surcharges in fact do *not* actually regulate risk spreading, insurance rates, or the solvency of insurers.

Because the surcharges are far "removed from the contractual relationship between the policyholder and the insurance company" (*Fabe*, 113 S. Ct. at 2216 (Kennedy, J., dissenting)), they are not within the common-sense conception of laws that regulate insurance. Because they cannot pass that analytical threshold, the surcharges are not saved from preemption by Section 514(b)(2)(A).

2. *The Surcharges Do Not Satisfy The Additional Criteria Set Forth In* Metropolitan Life.

Even if the surcharges could be said to regulate insurance under a common-sense view, they cannot survive scrutiny under the three additional factors that this Court used in *Metropolitan Life* and *Pilot Life*. Petitioners argue that, although this Court consistently has used those factors in its analysis of the ERISA savings clause, that clause is in fact broader than the similar savings clause in the McCarran-Ferguson Act, and the three-factor analysis must be modified. See, *e.g.*, Blues Br. 34-35; U.S. Br. 20. See *infra* pp. 44-48. This desperate attempt to escape the McCarran-Ferguson test

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[21] This position again marks a striking *volte-face* for the United States. In the past, the government argued successfully that a "common-sense interpretation" of the word "regulates" does not mean that the savings clause preserves every law that may "relate to" insurance, for sound reasons rooted in the text of ERISA: the limited scope of the savings clause is evident upon "comparison of the word 'regulate' in the saving clause with Congress's use of the phrase 'relates to' in the preemption clause. If Congress had intended to preserve state laws affecting insurance matters as broadly as it intended to preempt state laws affecting benefit plans, it could have used the phrase 'relates to' in the saving clause." U.S. Br. 14, *Pilot Life* (No. 85-1043).

is understandable: as four judges below unanimously concluded, the surcharges cannot survive that inquiry.

a. The surcharges do not regulate the transfer or spreading of policyholders' risk.

The surcharges quite plainly do not "regulate[] the spreading of risk." *Metropolitan Life*, 471 U.S. at 743. The relevant risk is "the risk the *policyholder* seeks to transfer in an insurance contract." *Fabe*, 113 S. Ct. at 2216 (Kennedy, J., dissenting) (emphasis added); see also *id.* at 2209 (opinion of the Court). Unlike the mandated-benefit law in *Metropolitan Life*, the hospital surcharges do not address that risk at all, but simply distort the prices ultimately paid to health care providers by some insurers and other persons.

In both *Royal Drug* (440 U.S. at 214) and *Pireno* (458 U.S. at 130), this Court held that efforts to control provider health care costs reimbursed by insurers did not involve the spreading of the relevant risk. It made no difference that such cost containment might enable insurers to charge lower premiums that would make insurance more affordable to a wider group of people, and thus potentially would allow greater risk-spreading on behalf of persons not yet insured.

The arrangement at issue in *Royal Drug* was functionally similar to the rate regulation at issue here: *Royal Drug* involved a private price agreement between insurers and providers, while in this case the State imposes the surcharge rate that hospitals must charge patients' insurers or other group benefit payors. The agreement in *Royal Drug* also involved the relationship between an insurer and a provider of health care services, but this Court held that such an agreement did not spread or transfer *policyholders'* risks. Rather, the risk affected was the obligation to reimburse drug costs, a risk that the insurer had assumed separately in its insurance contracts. 440 U.S. at 213-14 & n.12.

The surcharges at issue in this case are even farther removed from the risk-spreading function of insurance, because they directly address only the rates that hospitals charge patients. To the extent they involve insurance at all, the surcharges involve the same insurer-provider relationship at issue in *Royal Drug*; they do not regulate the transfer of policyholders' risks. They merely raise the cost of hospital services and, hence, the insurer's cost of satisfying its obligations on a risk it has already assumed.

Nevertheless, the courts below erroneously concluded that the surcharges have the effect of transferring or spreading policyholder risk merely because they might prompt "ERISA plans to shift to the Blues." Pet. App. A28. Whatever the secondary effects may be in terms of market distortion, the surcharges themselves do not regulate the "transfer of risk from insured to insurer * * * by means of the contract between the parties." *Fabe*, 113 S. Ct. at 2209 (quoting *Pireno*, 458 U.S. at 130). The surcharges transfer funds to the State and the hospitals from ERISA plans and other insurance purchasers, but do not regulate policyholders' risks at all.

b. The surcharges do not regulate any integral part of the policy relationship between insurer and insured.

Not only do the surcharges fail to regulate the transfer of policyholder risk; they also do not "regulate an integral part of the relationship between the insurer and the policyholder." *Metropolitan Life*, 471 U.S. at 743. Rather than "limiting the type of insurance that an insurer may sell to the policyholder" (*ibid.*), the surcharges attempt to influence ERISA plans to purchase insurance from a favored source.

Both lower courts correctly held that the surcharge laws do not regulate any practice that is integral to the policy relationship between the insurer and the insured. Pet. App. A26, A79. Indeed, New York conceded this point before the Second Circuit. C.A. Br. 36 n.47. Before this Court, however, New York now joins the other petitioners in contending (Br.

35) that the surcharge laws regulate an integral part of the relationship between the insurer and the insured, "albeit indirectly," because they "encourag[e] community rating and open enrollment." Those features, in turn, "ensur[e]" that a policy relationship may be formed independent of actuarial factors. *Ibid.* This argument cannot withstand scrutiny.

In the first place, hospital rate surcharges do not regulate any part -- much less an integral part -- of the policy relationship between the insurer and the insured. That result is not affected by the possibility that some insurers' costs may be reduced, and along with them the cost of health insurance for some applicants. In *Royal Drug*, this Court specifically held that agreements governing an insurer's payments to health care providers did not affect an integral part of the relationship between insurer and insured; it did not matter that the agreements lowered the insurer's cost of satisfying its policy obligations to its insureds, and thus might lower the cost of insurance. 440 U.S. at 215-17. The Court explained that the policy relationship between insurer and insured is "wholly separate" from the contractual arrangement between insurer and health care provider. *Id.* at 216 n.14; see also *Pireno*, 458 U.S. at 131. The surcharge laws at issue here set only the reimbursement rate for "payments to general hospitals" (New York Public Health Law, Section 2807-c(1)(b)) -- a transaction that likewise is clearly distinct from the obligations of an insurer to its insured.

In addition, although "[c]ommunity rating and open enrollment" may indeed "play an integral role in the policy relationship between insurer and insured," the surcharges simply increase the prices that hospitals charge patients with certain health coverage, and do not *regulate* community rating or open enrollment in any way. New York certainly knows how to accomplish the aims it espouses here: New York Insurance Law § 3231 expressly requires that commercial insurers engage in open enrollment and community rating in

the small group market. See *supra* p. 7 n.5. That law clearly regulates the affected insurance contracts.

By contrast, the surcharge laws do not change any of the terms, conditions, or scope of coverage in any insurance contract, they do not regulate the formation of insurance contracts, and they do not govern or seek to secure insurers' performance of their obligations to policyholders. Indeed, nothing in the surcharges even gives an insurer or other payor an incentive to offer community rating or open enrollment. HMOs already offer both features, yet they are still subject to the 9% surcharge. Self-insured plans must pay the 13% surcharge even though they are not licensed insurers and cannot engage in community rating or open enrollment. Commercial insurers were subject to a surcharge of 24% during the relevant period -- and still are surcharged 13% -- regardless of whether they offer community rating or open enrollment.[22] And the Blues do *not* pay the surcharges even for patients covered under large group contracts that are not community rated (J.A. 275).

In sum, not only do the surcharges not *regulate* any integral part of the relationship between insurer and policyholder, but they have no significant effect on that relationship.

c. The surcharge laws are not limited to entities in the insurance industry.

Finally, the surcharges do not "impose requirements only on insurers." *Metropolitan Life*, 471 U.S. at 743. The courts below unsurprisingly agreed that the surcharges are not limited to entities within the insurance industry. Pet. App.

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[22] The Blues mistakenly claim (Br. 40) that "until April 1, 1992, the [NYPHRM] statute * * * offered the incentive to commercial insurers to avoid a portion of the differential if they instituted open enrollment." In fact, this incentive lapsed at the end of 1990 (J.A. 227 & Exh. G thereto); regardless, it was not in effect when the Omnibus Act imposed the 11% surcharge and respondents commenced this case.

A26, A79. These laws prescribe requirements for hospital charges, not insurance companies.

The surcharge laws set the rates that hospitals must charge patients; neither hospitals nor patients are part of the insurance industry. Although the criteria for the surcharges refer in some case to insurance companies, they also refer to self-insured funds, HMOs, and individuals with no insurance at all.

In addition, by claiming that the surcharges are in fact limited to entities within the insurance industry, petitioners ask this Court to broaden the savings clause to encompass not only the regulation of insurance but also the regulation of medical service providers such as HMOs. See, *e.g.*, HANYS Br. 41. That invitation ignores the fundamental differences between an HMO and an insurance company.[23] Both courts below recognized that, as a matter of law, HMOs are not engaged in "insurance," the regulation of which is saved from ERISA preemption.

Although petitioners try to characterize HMOs as "insurers" that create security against loss from illness or accident and distribute the attendant financial risk, the Blues correctly concede (Br. 42) that "the role that HMOs play with members" is not to insure against unforeseen risks, but to "provide health care services for a fixed fee." As a result, courts long have held that HMOs are not engaged in the business of insurance. See, *e.g.*, *O'Reilly* v. *Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (ERISA savings clause);

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[23] The Blues (at 41) attempt to evade these differences by arguing that because HMOs may be subject to parts of the Insurance Law, they therefore are "persons" who are not "exempt" from "any law * * * which regulates insurance" (ERISA § 514(b)(2)(A)), and thus are "insurers" under the *Metropolitan Life* test. That circular reasoning begs the question whether the laws to which HMOs are subject in fact regulate *insurance* or merely regulate insurance companies and others. For the reasons explained in the text, HMOs do not in fact provide "insurance" and thus are not subject to laws that "regulate[] insurance."

Jordan v. *Group Health Ass'n*, 107 F.2d 239, 246 (D.C. Cir. 1939) (cited with approval in *Royal Drug*, 440 U.S. at 228). But see, *e.g.*, *Klamath-Lake Pharmaceutical Ass'n* v. *Klamath Medical Services Bureau*, 701 F.2d 1276, 1286-87 (9th Cir.), cert. denied, 464 U.S. 822 (1983) (McCarran-Ferguson Act). New York's regulatory scheme leads to the same conclusion, because the regulation of HMOs is plainly distinct from the regulation of insurance. Although the Public Health Law requires HMOs to comply with a few provisions of the insurance laws, HMOs need not be state-licensed insurers. Pet. App. A26-A27; N.Y. Ins. Law § 1109(a). Indeed, New York *forbids* HMOs to *call* themselves insurers. Pet. App. A27; N.Y. Pub. Health Law § 4411. Apparently, petitioners contend that the forbidden appellation may be applied to HMOs only for the purpose of saving broad state laws from preemption.

Petitioners insist that the 11% surcharge, at least, is limited to entities in the insurance industry because it is paid only by commercial insurance companies. N.Y. Br. 32; Blues Br. 33. But that is not true: under Section 348 of the Omnibus Act, the obligation to pay the 11% surcharge to the State does not fall upon commercial insurers. Rather, the *hospital* must add the surcharge to the bill of any patient covered by commercial insurance; it is the hospital, not the insurer, that risks civil penalties if the surcharge is not paid. See 1992 N.Y. Laws, ch. 41, § 104. New York deliberately chose *not* to impose the 11% surcharge on insurance companies.[24]

The surcharges plainly impose requirements and burdens on a broad array of persons and entities outside the insurance industry. Accordingly, the surcharges do not satisfy the third factor of the governing analysis.

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[24] In vetoing a bill that would have required commercial insurers to pay the 11% surcharge to the State, Governor Cuomo expressly stated that "any effort to shift payment responsibility to commercial insurers [would] trigger retaliatory statutes in other states, resulting in an additional tax to New York-based commercial insurers." C.A. App. 1232.

B. This Court Should Not Alter Its ERISA Pre-emption Analysis In Order To Preserve New York's Attempted Regulation Of ERISA Plans.

Recognizing that this Court's prior cases compel the conclusion that the surcharge laws do not fall within the savings clause, petitioners ask this Court to change the rules. Petitioners suggest that ERISA's savings clause sweeps more broadly than the McCarran-Ferguson Act and that, despite past practice, this Court should now apply the tripartite McCarran-Ferguson analysis -- if at all -- more leniently in ERISA cases than in antitrust cases. Petitioners also suggest that the decision in *Fabe* somehow requires this Court to modify its analysis under the ERISA savings clause. These arguments are entirely insubstantial.

1. For one thing, in both *Metropolitan Life* and *Pilot Life* -- this Court's only prior decisions applying the savings clause -- the Court relied heavily on the same criteria used under McCarran-Ferguson in *Royal Drug* and *Pireno*. The Court neither relaxed the application of those factors nor suggested that its analysis differed from the McCarran-Ferguson analysis.

Moreover, the fact that the ERISA savings clause refers to "insurance" while the McCarran-Ferguson Act refers to the "business of insurance" does not suggest that the ERISA savings clause has a broader sweep. If anything, the "business of insurance" connotes a broader range than "insurance" alone, because the "business of insurance" includes activities beyond the mere "contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specified perils." BLACK'S LAW DICTIONARY 802 (6th ed. 1990).

Petitioners point to nothing in the statute or this Court's decisions to indicate that the word "insurance" in ERISA should be construed more broadly than the words "business of insurance" in the McCarran-Ferguson Act. On the contrary,

the Court long has equated the terms, noting that ERISA and the McCarran-Ferguson Act "utilize similar language to define what is left to the States." *Metropolitan Life*, 471 U.S. at 744 n.21.

2. The United States proceeds down another blind alley when it argues (Br. 21-22) that the savings clause must preserve not only laws that "regulate insurance," but also laws "purporting to regulate insurance companies," on the ground that the broader formulation appears in the deemer clause (ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B)). That argument fails for a simple reason: the savings clause does not contain the "purporting to regulate" language. See *Ingersoll-Rand*, 498 U.S. at 141 (rejecting attempt to transplant "purporting to regulate" language from the deemer clause into the preemption clause). In fact, this Court indicated in *FMC* that the scope of the deemer clause on its face is "broader * * * than that of the saving clause" (498 U.S. at 64). That interpretation, and not the government's, is in keeping with the broad preemption principle that Congress enacted with only narrow exceptions (*Pilot Life*, 481 U.S. at 46), and comports with this Court's policy to "give effect, if possible, to every clause and word of a statute." *Fabe*, 113 S. Ct. at 2210 n.6. Beyond this, whatever the surcharges may accomplish in fact, they unquestionably *purport* only to set hospital rates. Section 2807-c is headed "General hospital inpatient reimbursement," and appears in the Public Health Law within an Article governing "Hospitals."

3. *Fabe* does not provide petitioners with any more help. On the contrary, the Court in *Fabe* reaffirmed that the contractual "relationship between the insurance company and its policyholders" is the focal point of the business of insurance for McCarran-Ferguson purposes. 113 S. Ct. at 2208. It is true that the Court held that the McCarran-Ferguson Act reaches state regulation of the performance of contracts as well as of contractual terms. But the Court's focus remained on *the insurance contract itself*; the Court also held, after all, that a

state law directed exclusively at insurance companies did not fall within McCarran-Ferguson except insofar as it *directly* regulated the contractual relationship with policyholders. See *id.* at 2212.

Petitioners seize upon a dictum in *Fabe* to the effect that the "broad category of laws enacted 'for the purpose of regulating the business of insurance'" includes "laws that possess the 'end, intention or aim' of adjusting, managing or controlling the business of insurance," a category broader than the "business of insurance" alone. *Id.* at 2210.[25] Petitioners insist that the ERISA savings clause also encompasses laws with the "end, intention or aim" of regulating insurance. The savings clause cannot bear that freight, however; by its terms, the clause preserves only laws that "regulate[] insurance," not all laws enacted for "the purpose of regulating insurance." The scope of the ERISA savings clause depends on whether state laws actually *regulate* insurance.

Likewise, in reading the first clause of Section 2(b) of the McCarran-Ferguson Act more broadly than the antitrust exemption in the second clause, this Court relied on the presence of the word "purpose" in the first but not the second clause. *Id.* at 2209-10 & n.6. That reasoning on its face defeats the argument that the ERISA savings clause should receive the broader reading, because the word "purpose" is nowhere to be found in that clause.

In addition, the ERISA savings clause and the second clause in Section 2(b) of the McCarran-Ferguson Act perform similar functions. In each case, the provision at issue prevents certain regulatory choices of a State from being overridden by the preemptive force of a specific federal law. This Court's analysis in *Pilot Life* and *Metropolitan Life* reflects the correct judgment that the ERISA savings clause raises questions of

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[25] In fact, the Court held that the statute at issue in *Fabe* did regulate the "business of insurance." *Ibid.*

statutory interpretation that are virtually indistinguishable from those in *Royal Drug* and *Pireno*. *Royal Drug* and *Pireno* turned on whether particular arrangements were part of the "business of insurance" and therefore exempt from the antitrust laws "to the extent * * * regulated by State law." 15 U.S.C. § 1012(b). Here, the inquiry is almost identical: the Court must determine whether a practice is "insurance," and whether a state law actually "regulates" it. 29 U.S.C. § 1144(b)(2)(A).

Most important, as we explained above, this Court's decision in *Fabe* confirms that even to come within the broad category of laws enacted "for the purpose of regulating insurance" -- a category broader than the actual regulation of insurance covered by ERISA's savings clause -- a state law must regulate the formation, terms, or performance of the contract between insurer and policyholder. The surcharge laws regulate none of these matters, and therefore do not fall within the coverage of the ERISA savings clause.

4. There are other important reasons for preserving this Court's long-standing analysis of the ERISA savings clause. To broaden the savings clause along the lines suggested by petitioners would obliterate the preemption principle that ERISA's sponsors considered the "crowning achievement" of the legislation. *Pilot Life*, 481 U.S. at 46 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)). As this Court has recognized, the sponsors' emphasis on "the breadth and importance of the preemption provisions" contrasts with their passing reference to the "narrow exceptions" to preemption. *Ibid.*

Under petitioners' view, however, states would be free to pass a broad assortment of laws interfering with the administration of ERISA plans so long as those laws could be said to have some impact on an ERISA plan's actions in the insurance marketplace -- or even had only the "stated purpose" (Blues Br. 32) of affecting the insurance market. Because plans and insurance companies both provide medical benefits, states could use putative "insurance regulation" to avoid

"through form" the substance of the preemption provision -- a result that "ERISA's authors clearly meant to preclude." *Alessi*, 451 U.S. at 525.

Following petitioners' open-ended rationale, virtually anything that a state legislature or insurance commissioner did to provide a commercial advantage for a favored insurance entity would be immune from preemption (and probably also immune from antitrust attack) -- no matter how disruptive of ERISA plans' operations and no matter how remote from regulation or taxation of insurance carriers themselves. The "narrow exceptions" would swallow the general rule. As with petitioners' proposal to narrow the preemption clause, such a sweeping change in the law should be left to Congress -- if it has any merit at all. It is the job of the legislature, not of the judiciary, to determine whether any "monumental changes * * * in the insurance marketplace" (Blues Br. 41) since the enactment of ERISA require adjustments in the terms of the Act.

C. The Deemer Clause Bars The Application Of The 13% Surcharge To Self-Insured Plans.

Even if this Court concludes that the 13% surcharge regulates insurance, that surcharge nevertheless is preempted insofar as it applies to self-insured ERISA plans. The deemer clause in Section 514(b)(2)(B) specifically "exempt[s] self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC*, 498 U.S. at 61. The deemer clause is as broad as the savings clause, if not broader; any law that is saved as an insurance regulation necessarily is preempted to the extent that it falls upon a self-funded plan. *Id.* at 64.

There is no dispute that, under Section 2807-c(1), self-insured plans may directly bear the burden of the 13% surcharge. The statute therefore is preempted to the extent it applies to those ERISA plans. No party seriously contests that conclusion of law. Petitioners (*e.g.*, HANYS Br. 37 n.32) and the United States (Br. 12 n.3) instead suggest that the

application of the 13% surcharge to self-funded plans is not before this Court. The record refutes that assertion.

To begin with, the complaints challenged the surcharge laws on behalf of self-insured plans. For example, Travelers sued as a fiduciary of the Sheridan Catheter Corporation's self-insured plan. J.A. 72-73; see also *id.* at 92-93 (other respondents suing in similar fiduciary capacities). Travelers' complaint expressly alleged that Section 2807-c(1)(b) "imposes a 13% surcharge for inpatient hospital care rendered to persons covered by * * * a self-insured ERISA plan such as the Sheridan Catheter Plan" (J.A. 81), and that "[i]n the case of a self-insured plan such as the Sheridan Catheter Plan, the 13% surcharge increases the overall cost to the plan of the claims administered by The Travelers" (*id.* at 82).

The district court, moreover, held that "those portions of the 13% [s]urcharge referring to self-insured plans could not possibly fall within the scope of the savings clause because * * * self-insured plans do not engage in the 'business of insurance' as a matter of law." Pet. App. A79. The district court later found that certain self-funded plans that refused to pay the surcharges were violating the court's stay of its order enjoining enforcement of the surcharges -- a violation possible only if that order encompassed the application of the surcharges to self-funded plans. (The district court's order to this effect, dated April 27, 1993, is attached as an appendix to the amicus curiae brief of the National Carriers' Conference Committee).

In fact, the Blues specifically appealed the district court's conclusion that "the savings clause could not apply to self-insured, as opposed to insured ERISA funds." Blues C.A. Br. 31; see *id.* at 39-40 (developing argument). Respondents devoted a section of their brief to respond to that argument (C.A. Br. 49-50), and the Second Circuit affirmed in full the injunction against enforcing the surcharges. Accordingly, even if this Court holds that the surcharges are saved from preemption when applied to insured plans, the Court should affirm the judgment of the court of appeals to the extent that it holds the surcharges preempted as applied to self-insured plans.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*; MARIO M. CUOMO, *et al.*; and HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

vs.

TRAVELERS INSURANCE CO., *et al.*, and NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE, INC., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

Whether Section 514(a) of the Employee Retirement Income Security Act of 1974 preempts section 2807-c(2-a) of New York's Public Health Law, which imposes a 9% assessment on HMOs, but not on any other health care delivery system?

RULE 29.1 STATEMENT

In accordance with Rule 29.1 of the Rules of this Court, respondents included a list of parent companies and subsidiaries in their Brief in Opposition to the Petitions for a Writ of Certiorari.

In addition to the individual health maintenance organizations ("HMOs") named as respondents in this action, the following HMOs are members of respondent New York State Health Maintenance Organization Conference, Inc.:

Aetna Health Plans of New York

ChubbHealth

Cigna Healthplan of New York

Community Health Plan (CHP)

Elderplan, Inc.

Health Care Plan, Inc. (HCP)

Health Insurance Plan of Greater New York (HIP)

Kaiser Foundation Health Plan of New York

Managed Health

Met Life Network

Patients' Choice, Inc.

PruCare of New York, Inc.

Sanus Health Plan

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STATEMENT

In 1974, Congress enacted the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1988 & Supp. V 1993) (hereinafter "ERISA"), in large part to protect employee benefit plans and the workers they serve. In enacting ERISA, Congress deliberately chose to include an expansive preemption clause, which preempts "any and all" state laws that "relate to" an employee benefit plan covered by the statute. The statute also expansively defines the concept of "employee benefit plan" to cover, through insurance or otherwise, the provision of medical, surgical or hospital care. Through these provisions, Congress intended to encourage the creation and expansion of innovative benefit delivery systems and to insulate those market-driven benefit delivery systems from burdensome and conflicting state regulation. H.R. Rep. No. 807, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4670, 4726; S. Rep. No. 383, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4890, 4935.

In the years since Congress enacted ERISA and its expansive preemption provision, employee benefit plans have proliferated. At the same time, however, the cost of health care has increased dramatically because of heightened demand and new medical technology. In response, many employee benefit plans have sought new ways to contain the escalation of health care costs without undermining the quality of care. One such way is to purchase health care coverage from a health maintenance organization or "HMO". By using a "managed care" approach that emphasizes primary and preventive care, HMOs are able to contain costs, while at the same time offering the high quality and comprehensive care upon which employers and employees insist.

In 1991, recognizing that managed care could succeed in both containing costs and improving quality, the State of New York established a managed care program for its Medicaid population. However, when enrollment in the program did not

occur at a pace that the State deemed sufficiently fast, the State opted to use harsher measures to induce HMOs to enroll more Medicaid recipients.

Specifically, in 1992, New York imposed a 9% assessment on the aggregate inpatient hospital costs that HMOs pay for their commercially-enrolled members. Significantly, this 9% assessment is *not* an increase in the rate that an HMO pays to hospitals for inpatient hospital services. Rather, the 9% penalty is assessed against the non-Medicaid costs of inpatient care and is remitted to an agent of the State, who then deposits the money into the State's general fund. An HMO can reduce or eliminate this 9% assessment only if it enrolls a statutorily-defined target number of Medicaid recipients.

The 9% assessment does not apply to any other third party payor (such as commercial insurance companies or Blue Cross/Blue Shield indemnity plans); nor does it apply to self-insured companies. Rather, the full impact of the 9% assessment falls on HMOs and, in turn, on the employee benefit plans that comprise the vast majority of HMOs' subscribers.

Thus, with regard to the 9% assessment, the question before the Court is distinctly and definitely *not* whether ERISA preempts any and all state regulation of hospital rates, as petitioners suggest. Rather, with regard to the 9% assessment, the question is whether ERISA preempts a state statute that deliberately interferes with and substantially burdens one of the means through which ERISA plans obtain and provide quality health care for their participants.

A. HMOs and Their Role in New York's Health Care System

The New York State Health Maintenance Organization Conference consists of 25 HMOs licensed to operate in, and located throughout, the State of New York. The HMOs in the Conference currently provide health care to over three million people in New York. The twelve HMOs that have intervened

in this case serve well over one million people located in all parts of the State. JA-260.

HMO coverage differs from traditional indemnity health insurance in several important respects. Traditional indemnity insurance generally covers people if and when they become ill and need medical services and/or hospitalization. After the policyholder has received and often paid for the services, the policyholder submits the claim to the insurance company and receives some percentage of the total cost, often after subtracting a deductible.

In contrast, HMOs are integrated systems of health care that emphasize maintaining the health of HMO members rather than reimbursing policyholders for claims incurred after the policyholder has already fallen ill. By combining inpatient hospitalization coverage with the provision of primary, preventive and specialty care, HMOs are able to provide quality health care in a cost efficient manner. JA-261.

HMOs provide or arrange for such care through a variety of contractual arrangements with doctors, other providers and hospitals. Some HMOs (staff and group models) employ their own physicians. Physicians employed by or affiliated with staff or group model HMOs generally serve only members of the HMO and are not available to serve the public at large. Other HMOs (individual practice associations or "IPAs") use networks of physicians who agree to serve the HMO's subscribers and adhere to the HMO's practice standards and payment guidelines. JA-261.

An even more significant difference between HMOs and indemnity insurers is that HMOs manage the provision of medical care and hospitalization. Under an HMO "managed care" system, an HMO member must select a primary care physician from the HMO's staff or network, who, in effect, "manages" the care for that individual. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(b),(c) (1992). If specialty care is needed, the member must generally obtain a referral from the primary care physician and usually is referred to other

physicians who are on the staff, or in the network, of the HMO. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(c),(d) (1992). JA-263. In the case of a member with a serious illness, a medical director will work with the primary care physician, specialty care physician, hospital and others to insure that the care being provided is coordinated and that there is a comprehensive treatment plan.

As part of their philosophy of preventive care, HMOs provide a far more comprehensive package of benefits than that offered by most indemnity insurance policies and plans. *See* 42 C.F.R. §417.101 (1993). The comprehensive benefits package that HMOs offer includes full coverage of primary and preventive care, such as immunizations, prenatal care, well-baby and well-child care, mammograms, cholesterol screenings, and numerous other services intended to maintain the health of the HMO member. JA-262. In contrast, an indemnity insurer or self-insured plan may offer a bare-bones policy, such as hospitalization coverage only.

In exchange for agreeing to abide by the rules of the HMO, employee benefit plans and other HMO subscribers pay a monthly or quarterly fee that is almost always below the cost of an indemnity insurance policy with comparable benefits. Unlike indemnity insurance policies, which often have high deductibles and co-payments, HMOs require very little out-of-pocket expense and impose only minimal co-payments. Moreover, HMOs require little, if any, paperwork. Because an HMO is based upon the principle of prepaid health care, it is not necessary to pay for services and then submit claim forms to obtain reimbursement. Rather, most HMO members need only show their HMO cards and pay the co-payment, if any, in order to receive health care services.

HMOs also have the financial incentive and statutory responsibility to maintain quality assurance programs. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.12 (1993). For example, in New York, HMOs are responsible for credentialing physicians, maintaining continuity of care, reviewing charts

and overseeing the care that is provided. *Id.* HMOs also provide formal grievance procedures to permit HMO members the opportunity to challenge decisions with which they disagree. N.Y. Pub. Health Law § 4403(1)(g) (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.14 (1992). The New York State Health Department conducts triennial reviews of every HMO in which it examines the entire operation of the HMO, including the quality assurance program. N.Y. Pub. Health Law § 4409 (McKinney 1985). In contrast, traditional indemnity insurers are not responsible for the quality of care that policyholders receive because the insurance company merely reimburses claims for care provided by independent medical professionals and institutions.

HMOs differ in other major respects from insurers. For example, unlike commercial insurers, which traditionally have relied on experience rating, and unlike Blue Cross companies, which experience rate groups with more than fifty members, HMOs community rate large groups, small groups and individuals.[1] JA-261. HMOs always have been required to open enroll groups of five or more employees and, under recently enacted legislation, are now required to open enroll even very small groups and individuals. N.Y. Ins. Law § 3231 (McKinney Supp. 1994); JA-261-62. Moreover, in contrast to indemnity policies, HMOs do not impose lifetime caps on the amount of benefits that they provide. *See* 42 U.S.C. § 300e(b)(1991). Thus, chronically or severely ill individuals may continue to receive coverage regardless of the amount of health care services that they have utilized.

Finally, unlike commercial insurers and Blue Cross/Blue Shield indemnity insurance plans, HMOs serve Medicaid

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[1] "Community rated" refers to a rating methodology in which the premium for all persons covered by a policy or contract is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation. N.Y. Ins. Law § 4317(a) (McKinney Supp. 1994).

recipients. Under the State's Medicaid managed care program, HMOs enroll Medicaid recipients into their networks and are responsible for providing Medicaid recipients and their families with primary care physicians. When an HMO enrolls a Medicaid recipient, it accepts the risk of serving that individual regardless of the individual's health status. *See generally* N.Y. Soc. Serv. Law § 364-j *et seq.* (McKinney 1992 & Supp. 1994); N.Y. Comp. Codes R. & Regs. tit. 18, § 360-10 *et seq.* (1991). In return, the State pays HMOs a fixed monthly rate for each individual based on the average cost of serving Medicaid recipients. JA-262, 337-338.

B. HMOs And Employee Benefit Plans

Disenchanted with the increasing cost, paperwork and uncertain quality often associated with indemnity insurance, many employee benefit plans have in recent years turned to HMOs to provide health care coverage to the participants of their plans. As a result, enrollment in HMOs has increased substantially, with ERISA plans making up the great majority of HMOs' subscribers. *See, e.g.*, JA-144. The only HMO subscribers that are not ERISA plans are government plans such as Medicaid and Medicare, individuals, and employee benefit plans that are exempt under ERISA -- *e.g.*, governmental entities or exempt organizations such as churches.

Many ERISA plans now rely exclusively on one or more HMOs to provide care to their participants. Other ERISA plans offer employees a choice between indemnity coverage and HMO coverage. However, it is common for ERISA plans offering such a choice to pay only the cost of the lowest priced HMO. In this situation, the HMO becomes the "benchmark" health benefit plan and the employees must bear the additional cost if they choose higher priced indemnity coverage.

Moreover, many ERISA plans that rely heavily on the managed care systems of HMOs have, working together with the HMOs, developed extensive quality assurance programs extending beyond the requirements imposed by many states. These quality assurance programs are applicable only to

HMO-provided care because it is virtually impossible to measure quality in the open-ended system that exists under fee-for-service indemnity insurance. Thus, many ERISA plans have, for both cost and quality reasons, structured their health care benefits around the managed care systems of HMOs.

Finally, many ERISA plans purchase riders for health services from HMOs that are supplementary to the core benefits provided as part of the HMO's standard benefit package. Riders are often used to offer supplemental benefits such as pharmacy, dental, vision and expanded hospitalization for rehabilitative services. 42 U.S.C. § 300e-1(2) (1991). Because these benefits are add-ons to the core policy, they are often the first to be cut in the event that the ERISA plan must reduce health care costs.

C. The 9% Assessment and Its Impact On Employee Benefit Plans

In April 1992, in the midst of a severe State fiscal crisis, New York enacted a 9% assessment on the cost of inpatient hospital care paid by HMOs in the state. N.Y. Pub. Health Law §§ 2807-c(2-a)(a)-(e) (McKinney 1993). The 9% assessment is not an increase in the actual rates that HMOs pay to hospitals for inpatient care. Rather, this separate charge is based on the aggregate monthly cost of the inpatient hospitalization furnished to HMO members and is paid by the HMO into a statewide pool. The pool administrator then deposits the funds into the State's general revenue fund. *Id.*

The 9% assessment thus differs sharply from the 13% and 11% surcharges also at issue here because the 9% assessment is *not* an increase in the rate of payment to hospitals. The rate that an HMO pays a hospital is unaffected by the 9% assessment, and the 9% assessment produces no revenue for hospitals.

An HMO can reduce or eliminate the 9% assessment only if the HMO achieves the State-established Medicaid enrollment objectives: (1) the HMO has Medicaid contracts

with every county in which it operates; and (2) the HMO enrolls a statutorily-defined target number of Medicaid recipients. N.Y. Pub. Health Law §§ 2807-c(2-a)(a)-(e); JA-264.

For an HMO that did not already have Medicaid contracts in place and a substantial Medicaid enrollment at the time of the enactment of the 9% assessment in 1992, it was virtually impossible for the HMO to satisfy the requirements for eliminating the assessment for the 1992 assessment period. Because the law was enacted in mid-April of 1992 and the measuring date to determine whether the HMO had achieved its target was May 1st of the same year, an HMO that did not have county contracts in place and had not already achieved its target at the time the statute was enacted had only two weeks to obtain any necessary contracts and enroll the requisite number of Medicaid recipients. JA-265. The result was that, for the 1992 assessment period, few HMOs qualified for elimination or reduction of the 9% assessment. JA-177. All other HMOs had to pay this substantial assessment to the State's general revenue fund.

Moreover, even those HMOs that are able to eliminate or reduce the 9% assessment in a particular year have no assurance that they will continue to be able to do so because the enrollment target increases each year.[2] JA-265. In addition, because there is no corresponding mandate on Medicaid recipients to enroll in an HMO, HMOs with

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[2] The target number of the statute presently being challenged was determined by multiplying an HMO's share of the commercial market in a county times the greater of three measures: (1) 5% of the total Medicaid population; (2) the actual number of Medicaid enrollees; or (3) the enrollment target set in the State's Medicaid managed care plan. The statute has subsequently been revised, and the target is now based on the percentage of Medicaid recipients in the HMO's service area multiplied by the HMO's commercial enrollment. The target increases annually over a five-year period until fifty percent of all New York State Medicaid recipients are enrolled in managed care. 1993 N.Y. Laws ch. 731.

sufficient enrollment in one year may nevertheless lack the requisite enrollment in the next year and thereby become subject to the 9% assessment. JA-265.

The assessment had, and continues to have, an immediate and substantial impact on the rates that HMOs must charge their ERISA plan subscribers. Because the cost of inpatient hospitalization accounts for approximately 40% of the overall costs of an HMO, the 9% assessment translated into an immediate increase of up to 3.5% in total costs for most HMOs. JA-265. This is a cost that has been directly and exclusively imposed on HMOs (and not on any other third-party payors such as indemnity insurers).

As the State understood when it enacted the 9% assessment, HMOs could not and cannot absorb this substantial increase in cost. JA-265. While HMOs maintain reserves, the reserves must be retained in the event that an HMO experiences unusually heavy medical costs. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.11 (1992). Moreover, many HMOs are not-for-profit, including seven of the individual intervenor HMOs, and have no surplus or profit to fund the assessment. JA-107-09.

Therefore, in the face of the 9% assessment, which for some HMOs amounts to millions of dollars per year, HMOs have had no choice but to seek to impose a rate increase onto their rate subscribers. JA-262. In fact, the New York State Insurance Department recognized that the 9% assessment was an expense that HMOs could not absorb and has granted rate increases that reflect the amount of the 9% assessment. JA-265-66. For example, Oxford Health Plans was awarded a 2.6% increase for the last three months of 1992 to reflect the cost of the 9% assessment it was then paying. Exhibit "B" annexed to R. 32 (JA-19).

The rate increases resulting from the 9% assessment have fallen almost exclusively on ERISA plans, which comprise the great majority of HMO subscribers. *E.g.*, JA-144. Significantly, the State chose not to impose the 9%

assessment on hospital costs attributable to the Medicaid program, for which the State is largely responsible. N.Y. Pub. Health Law § 2807-c(2-a)(c). And, because the amount that Medicaid pays to an HMO to provide care to a Medicaid recipient in the managed care program is based largely on the average costs of serving the Medicaid recipient, 42 C.F.R. §434.40 (1993), exempting Medicaid hospital costs from the 9% assessment has had the effect of insulating the State in its role as a payor from the effects of the 9% assessment. Thus, the burden of the 9% assessment, by design, falls almost exclusively on the ERISA plans that make up the vast majority of the HMOs' remaining membership.

D. Decisions of the Courts Below

Both the district court and the court of appeals held that the 9% assessment had the requisite connection with and effect on ERISA plans to justify and require preemption. Although both courts recognized that the 9% assessment placed a substantial economic burden on HMOs and the ERISA plans that subscribe to them, it was the design of the statute and the resulting burden on ERISA plan structure and administration that was found to "relate to" ERISA plans for purposes of the courts' preemption analyses.

1. As a preliminary matter, the district court rejected the petitioners' assertion that the assessment had only a "tenuous and remote" economic effect on ERISA plans, stating that "there can be little doubt that the Surcharges at issue will have a significant effect on the . . . HMOs which do or could provide coverage for ERISA plans ...." Pet. App. A-71. Judge Freeh found that some HMOs pass the increased cost associated with the assessment through to their ERISA plan subscribers. Pet. App. A-74. To the extent that this increased cost imposed a substantial economic burden on the ERISA plans, Judge Freeh held that the assessment could improperly burden the structure and administration of such plans. Pet. App. A-73.

The district court also found that some plans might opt to "reduce the level of benefits or services offered rather than

increase costs to participants -- a burden on plan administration which ERISA was designed to avoid." Pet. App. A-73-74. Moreover, the court noted that, if plans do reduce the level of benefits, the assessment will likely result in the imposition of "inconsistent obligations upon multi-state plans -- exactly the type of burden ERISA's preemption clause was intended to prevent." Pet. App. A-74. Thus, the court held that the 9% assessment "related to" ERISA plans. Pet App. A-73-75.

Having found that the 9% assessment "related to" ERISA plans, the district court next examined ERISA's insurance savings clause to determine whether the assessment was exempted from preemption as a law regulating the business of insurance. The court unequivocally held that the 9% assessment "could not possibly fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." Pet. App. A-79.

2. The court of appeals commenced its preemption analysis by noting that, because the HMOs would be forced either to increase plan costs or reduce benefits, the 9% assessment "purposely interfere[s] with the choices that ERISA plans make for health care coverage." JA-52. The court found that this purposeful interference constituted the requisite connection with ERISA plans to trigger ERISA preemption. JA-52.

In the court of appeals, none of the petitioners challenged the district court's finding that the 9% assessment did not fall within the insurance savings clause. JA-57. Nonetheless, the court of appeals adopted the district court's determination that, because HMOs are not insurers as a matter of law, the 9% assessment did not fall within ERISA's insurance savings clause. JA-57, 60. The court also concluded that the 13% surcharge was not saved as a law regulating the business of insurance because it was not limited to entities in the insurance industry, relying in part on its determination that HMOs are not insurers as a matter of law. JA-60. As part

of its reasoning, the court emphasized that HMOs are not required to be state licensed insurers and may not include in their names "words generally regarded as descriptive of the insurance function." JA-57, 60. Thus, the court of appeals found that the 13% and 11% surcharges, as well as the 9% assessment, were preempted by ERISA.

SUMMARY OF ARGUMENT

Although the Court has recognized that ERISA's pre-emption provision is complex, the Court has never wavered from its initial view, first expressed in 1981, that the preemption clause is exceptionally broad. This is not surprising given that the Court's view stemmed not only from the language of the preemption clause but also from the statute's broad definition of the "employee benefit plans" that the preemption clause was intended to protect. When this language is read in the context of a statutory structure that exempts from preemption only a few specific areas of state regulation, there can be little doubt that Congress intended the preemption clause to sweep away virtually all state interference with employee benefit plans.

Underlying this statutory text was a congressional recognition that rigid governmental regulation of the market of employee benefits would be counter-productive to the goal of protecting employee benefit plans and their participants. Congress knew, and so stated, that the structure and administration of employee benefit plans involved trade-offs and decisions that would inevitably reflect the unique characteristics of each benefit plan. Congress also recognized that the market -- rather than the government -- could best respond to and meet these unique needs. That is why, after establishing certain federal ground rules for benefit plans, Congress at the same time prevented the states, through the preemption clause, from interfering with ERISA plan decisions.

Of all the decisions that were left to employee benefit plans, Congress was perhaps most protective of decisions

regarding health care benefits. Indeed, the definition of "employee benefits plan" specifically refers to the provision of health care benefits and places the responsibility for providing such benefits on the employee benefit plan. In doing so, Congress understood that plans often would not provide the benefits themselves; rather, they would ordinarily provide the benefits through insurance or other means. Thus, the *decision* as to how best to provide health care benefits is, under the explicit language of the statute, a core function of the plan.

The 9% assessment at issue in this case is preempted precisely because it interferes with this core decision. It does so because it imposes a significant penalty not on all ERISA plans, but rather only on those ERISA plans that choose to provide health care benefits through an HMO. Because the assessment is targeted only at HMOs, and not at any other delivery system, the 9% assessment penalizes, and interferes with, the ERISA plan's choice of delivery system.

While such interference would, in all cases, be disruptive to an ERISA plan, it is particularly disruptive to plans that have opted to provide health care benefits through the managed care delivery systems of HMOs. Unlike indemnity insurance, HMOs provide or arrange for health care and do so with a philosophy and system that often cannot be replicated. Because the HMO assumes the plan's responsibility for providing the health care benefits, the HMO acts as an alter ego to the plan. Thus, imposing a 9% assessment on the HMO is akin to imposing the assessment directly on the plan. For this reason alone, the 9% assessment "relates to" ERISA plans.

The record also demonstrates that the disruption with ERISA plans is substantial. The district court and the court of appeals both found that the 9% assessment resulted in higher costs and/or reduced benefits for ERISA plans. Moreover, by forcing HMOs to enroll Medicaid recipients even if the HMO's delivery system does not have the capacity to absorb properly such members, the 9% assessment dramatically

interferes with an HMO's ability to deliver health care services to its members. In short, the 9% assessment constitutes a substantial state interference with ERISA plans.

The decisions of the Court have consistently held that states may not intrude into this protected area. The 9% assessment is, if anything, more intrusive than many of the state laws that the Court has previously found to be preempted. Finding preemption here would simply reiterate what the Court has said before: states may not interfere -- directly or indirectly -- with the structure, administration and decisions of ERISA plans.

Unlike the 13% and 11% surcharges, the petitioners acknowledge that the 9% assessment does not fall within the insurance savings clause. Accordingly, since the 9% assessment "relates to" ERISA plans, the Court should affirm the court of appeals and hold that the 9% assessment is preempted.

ARGUMENT

In contrast to the 13% and 11% surcharges at issue in this case, the 9% assessment is *not* payable to hospitals and *must* be paid by HMOs (and, in effect, their subscribers), but not by any other payors (or their subscribers). Thus, many of the arguments that petitioners make in defense of the 13% and 11% surcharges are, on their own terms, inapplicable to the 9% assessment; and, by the admission of petitioners, ERISA's so-called insurance "savings clause" is not even arguably applicable to the 9% assessment. Thus, the 9% assessment on HMOs presents a separate and distinct question of ERISA preemption for the Court to resolve, a question that we believe is easily resolved in favor of ERISA preemption.

I. THE 9% ASSESSMENT IS PREEMPTED BECAUSE IT "RELATES TO" ERISA PLANS

In enacting ERISA in 1974, Congress sought to encourage the growth and development of employee benefit plans by the private markets. Congress recognized, however, that

> [S]ince these plans are voluntary on the part of the employer and . . . increases in benefits depend upon employer willingness to participate or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage . . . and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans. At the same time, there are advantages in setting minimum standards in these areas both to serve as a guideline for employers in establishing or improving plans and also to prevent the promise of more in the form of . . . related benefits than eventually is available.

S. Rep. No. 383, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4840, 4935. Accordingly, as this Court has recognized, Congress chose not to dictate the substantive contents of such plans, but rather to establish certain baseline rules and then leave it to the marketplace to define the contents of the plans and the way in which such benefits would be delivered. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981) ("ERISA leaves this question [the content of benefits] largely to the private parties creating the plan. [T]he private parties, not the Government, control the level of benefits . . . ."). Congress recognized both that a flexible market was more likely to produce innovative benefit plans that are responsive to employee needs than a rigid system of government-regulated benefits and that excessive governmental intervention in this area would unduly discourage the establishment of employee benefit plans in the first instance. *See id.* And, to insure that the states did not interfere with, burden or impose multiple obligations in this regard, Congress included within ERISA both an expansive preemption provision and a broad definition of the employee benefit plans to which that preemption provision would be applicable.

The 9% assessment clearly intrudes into this congressionally-protected sphere. By targeting the managed care systems of HMOs, the 9% assessment directly regulates -- differently and even more starkly than the 13% and 11% surcharges -- one of the statutorily-contemplated means by which ERISA plans deliver their benefits. Moreover, the 9% assessment does not apply to the cost of hospital services provided by all ERISA plans. Rather, it applies only to the cost of hospital services provided by ERISA plans that have chosen to provide health care through HMOs. These ERISA plans made a deliberate decision to offer plan participants the lower cost, comprehensive benefits and quality assurance programs of HMOs, and the State of New York has interfered with their decision by singling out this particular means of health care delivery and substantially and purposefully burdening it with an expensive assessment. In so doing, the 9% assessment runs roughshod over the decisions made by these plans as to how best to provide benefits to plan participants and thereby frustrates the intent of Congress to leave such decisions to the unregulated market.

The text of ERISA and the nature of the state interference make it clear that this case falls readily within the category of state laws that the Court has previously found preempted. Indeed, contrary to petitioners' arguments, the decision below does not extend ERISA preemption doctrine in the slightest. By employing the same analysis used by the Court in other preemption cases that apply this statute's "relate to" language, *see, e.g.*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 725 (1985); *Morales v. Trans World Airlines, Inc.*, 112 S. Ct. 2031, 2038 (1992), the court below correctly held that the 9% assessment does not test the outer limits of the preemption clause but rather falls well within the boundaries set by the statutory scheme and the Court's prior interpretations of it.

A. The Statutory Text and Structure of ERISA Show That The Preemption Clause Extends to Laws that Purposefully Interfere With and Substantially Burden the Means Through Which ERISA Plans Deliver Health Care Benefits to their Participants

As noted above, in order to promote the growth of and innovation in employee benefit delivery systems by the free market, Congress enacted a preemption clause that is "conspicuous for its breadth". *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Specifically, ERISA's broad preemption clause provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[s] . . . ." 29 U.S.C. § 1144(a). This preemption clause is as expansive as any that Congress has enacted. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) ("broadly-worded pre-emption provision"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) ("[t]he express pre-emption provisions of ERISA are deliberately expansive"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983) (the "breadth of [the provision's] pre-emptive reach is apparent from [its] language.").

By preempting any and all state laws that "relate to" employee benefit plans, Congress very deliberately chose language whose ordinary meaning of " 'to have bearing or concern; to pertain; refer; to bring into association with or connection with' . . . express[es] a broad pre-emptive purpose." *Morales*, 112 S. Ct. at 2037 (quoting Black's Law Dictionary 1158 (5th ed. 1979)). Indeed, Congress chose to define the term "State", for preemption purposes, to include a state or any agency or instrumentality thereof "which purports to regulate, directly *or indirectly*, the terms and conditions of employee benefit plans." 29 U.S.C. § 1144(c)(2) (emphasis added). Thus, the Court has interpreted the key phrase -- "relate to" -- to mean that ERISA preempts any state law that has a "connection with or reference to" any ERISA benefit

plan. *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992); *Ingersoll-Rand*, 498 U.S. at 138-39; *Shaw*, 463 U.S. at 96-100.

Moreover, the Court has held that preemption is not limited to "state laws specifically designed to affect employee benefit plans." *FMC Corp.*, 498 U.S. at 58; *see also Shaw*, 463 U.S. at 98. Rather, it has held that ERISA preempts state laws "even if the law is not specifically designed to affect such plans, or the effect is only indirect . . . ." *Ingersoll-Rand*, 498 U.S. at 139; *see also Alessi*, 451 U.S. at 525 ("[E]ven indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.").

In this regard, Congress broadly defined the "employee welfare benefit plan[s]" to which any preempted state law must "relate." "Employee welfare benefit plan" is defined as any "employee welfare plan", which, in turn, is defined as:

> any plan, fund or program . . . maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical or hospital care or benefits . . . .

29 U.S.C. § 1002(1) (1985) (emphasis added). Thus, "employee benefit plan", as referred to in the preemption clause, explicitly includes within its scope the means through which employee benefits such as health care are provided. *See Metropolitan Life*, 471 U.S. at 727-30, 739. And these means include not only insurance but other means, such as HMOs, that provide health care directly to plan participants.

This understanding of the breadth and reach of the preemption provision is further demonstrated by the statutory structure that Congress created. In that statutory structure, Congress carefully enumerated the specific areas in which state authority would be preserved. Those areas are contained

in subdivision (b) of section 1144, which exempts state laws "regulating" insurance, banking, or securities, 29 U.S.C. § 1144(b)(2)(A), and "any generally applicable criminal law." 29 U.S.C. § 1144(b)(4). This limited exemption of a few select areas from the preemption clause constitutes a considered and deliberate approach to preemption. It makes clear both that Congress intended for the preemption clause to have broad reach and, more particularly, that the preemption clause would apply to laws that, even though not directly regulating employee benefit plans, regulate the means by which employee benefits are delivered -- *e.g.*, insurance. *See Metropolitan Life*, 471 U.S. at 732 (state law regulating health insurance purchased by employee benefit plans "relates to" such plans). And, while Congress preserved through the savings clause state regulation as to some means of providing benefits (such as insurance), the statutory structure reveals that it did not similarly save -- in this statute at least -- state laws that regulate any other means of providing benefits.

B. The 9% Assessment "Relates to" ERISA Plans that Provide Health Care Benefits through HMOs

Against this statutory background, it is clear that the 9% assessment "relates to" ERISA plans. The 9% assessment directly regulates one of the means through which ERISA plans deliver health care benefits. In doing so, it imposes substantial economic and other burdens on ERISA plans that choose to use HMOs. Moreover, it imposes this burden only on HMOs (and not on other payors), and thereby purposefully interferes with ERISA plans' decisions as to their chosen means of benefit delivery systems. Accordingly, the 9% assessment is just like other laws that this Court has found preempted because they interfered with ERISA plans. By affirming the court of appeals' decision in this case, the Court will further the purposes of the preemption clause -- namely, to protect from state interference the free market's provision and delivery of employee benefits.

1. The 9% Assessment Has The Requisite Connection With ERISA Plans

At the outset, it is important to understand that the 9% assessment plainly "relates to" "employee benefit plans," as those terms are contemplated by the statute. ERISA expressly recognizes that "employee benefit plans" will provide their benefits "through insurance or otherwise." Thus, a law that regulates the means by which an ERISA plan delivers its benefits is self-evidently a law that has a "connection with" ERISA plans.

When an ERISA plan opts to obtain health care coverage from an HMO, it is not purchasing insurance; rather, the plan is purchasing a philosophy and a system of care. Participants in ERISA plans select the HMO as a benefit option, and the HMO provides the medical care. Thus, there is a confluence between the employee benefit plan and the HMO, which is the entity that is actually "providing for [the] participants . . . the medical, surgical or hospital care" set forth in the statute. The HMO is, in essence, a surrogate for the ERISA plan.

Accordingly, the 9% assessment cannot properly be distinguished as a law that regulates HMOs -- which are the means for delivering benefits -- but yet does not regulate the delivery system itself. To the extent that such a distinction might have any relevance in the commercial insurance context -- and frankly we are inclined to think that it has none -- it plainly has no application in the HMO context. Thus, when the 9% assessment is applied to HMOs, it is in effect being applied to the ERISA plans that have chosen to use HMOs as their means of delivering health care to their participants.

Indeed, because the 9% assessment applies only to HMOs, it penalizes those ERISA plans that have chosen to use HMOs as the means for delivering benefits to their participants. The 9% assessment imposes a monetary penalty on HMOs that fail to meet the State's Medicaid enrollment target and thereby purposefully burdens the means by which

their ERISA plan subscribers have chosen to provide health care coverage to their participants. In contrast to the 13% surcharge, which at least reimburses hospitals for services, the 9% assessment penalizes ERISA plans and burdens their options in order to induce behavior from the HMOs that is entirely unrelated to the provision of hospital services.

This statutorily-proscribed burden on ERISA plans occurs in part because HMOs have little choice but to pass the assessment through to their ERISA plan subscribers. As the State well knows, although HMOs maintain reserves, they are not entitled to use these funds to offset day-to-day operating expenses. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.11(d). Thus, the HMOs must transfer the cost of the assessment, in the form of higher rates, on to their ERISA plan subscribers. Indeed, it was the very fact that the assessment would adversely affect an HMO's relationship with its ERISA plan subscribers that caused the State to choose the assessment as the most effective way to induce HMOs to participate in the State's Medicaid managed care program.

These burdens are particularly pernicious because the 9% assessment is applicable only to HMOs. Many ERISA plans choose HMO coverage precisely to obtain the comprehensive benefits, lower out-of-pocket costs, and lower overall premiums that are the hallmarks of HMOs. For example, it is common for ERISA plans to move from more expensive indemnity insurance to HMO coverage in order to generate savings in the cost of health care -- savings which may then be used to fund improvements in salaries or other benefits that are provided by ERISA plan sponsors. Similarly, ERISA plans also transfer to HMO coverage to reduce the out-of-pocket costs to employees who may be paying high deductibles and co-insurance under indemnity insurance coverage and to provide plan participants with quality assurance programs and comprehensive benefits, such as well-child care, while staying within the cost envelopes that previously existed.

The 9% assessment interferes with and burdens this conscious selection of a benefit option by undermining the HMO's ability to provide the very thing for which an ERISA plan has bargained -- namely lower costs, comprehensive benefits and quality assurance. By burdening the cost of health care for only one segment of the health care coverage market -- HMO-provided managed care but not indemnity insurance -- the 9% assessment strikes at the heart of an ERISA plan's decision as to how best to provide health care to its participants.

The blow to ERISA plans is not simply in higher costs. The 9% assessment also burdens the HMO's ability to provide health care services to ERISA plans. To avoid the 9% assessment, the HMOs must, if possible, increase the number of Medicaid enrollees that they serve. But to do so, the HMOs must, among other things, divert some of their finite delivery capacity, which could result in increases in the waiting time for non-acute medical services provided to ERISA plan participants. As the State itself recognized when it amended the law to account for such "capacity" issues, 1993 N.Y. Laws ch. 731, these burdens are serious and directly affect ERISA plans.

It is for these very reasons that the Secretary of Labor argued in the court of appeals that the 9% assessment relates to ERISA plans:

> First, the surcharges "refer to" plans because they single plans out for differential treatment -- treatment that is worse than that accorded certain other purchasers of hospital services. For example, a self-funded plan or a plan insured with a commercial insurer must pay the 13% surcharge on hospital rates, while Blue Cross/Blue Shield is exempt. Similarly, plans insured with commercial insurers are also subject to the 11% surcharge, but the Blues are not. Finally, plans that contract with HMOS are liable for the 9% surcharge from which all other individuals and plans are excused.

. . .

> In addition, the surcharges have a "connection with" plans, for their intent and effect is to alter plan behavior. The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% charges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge. *Shaw, Metropolitan v. Massachusetts and General Electric v. New York Dep't of Labor* all hold that such changes in plan structure and benefit levels constitute the requisite "connection" for purposes of § 514.

(U.S. Ct. App. Br. at 19-20.) While the Government has reversed its position in this Court, it provides no rationale for doing so, much less an explanation as to why its initial position was incorrect. And its current approach is flatly inconsistent with Congress' intent that ERISA plans have the flexibility to structure benefit plans and their delivery systems free from state interference.

Contrary to petitioners' arguments, (*see* Brief of the New York State Conference of Blue Cross and Blue Shield Plans ["Blues Br."] at 20; Brief of Mario M. Cuomo et al. ["N.Y. Br."] at 13-17; Brief of Hospital Association of New York State ["HANYS Br."] at 17-18), it is of no significance that the State has attempted to accomplish this market intervention by imposing the 9% assessment on the HMOs rather than directly on the ERISA plans. As noted above, the statute expressly defines "employee benefit plan" as including the means through which the benefit plan delivers its benefits -- including "insurance or otherwise." 29 U.S.C. § 1002(1). And, as the Court has frequently recognized, state intervention in the market of employee benefit delivery

systems is prohibited even if "the effect is only indirect." *Ingersoll-Rand*, 498 U.S. at 139; *accord*, *Alessi*, 451 U.S. at 525 ("It is of no moment that [the state] intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called 'pension regulation'"); *FMC Corp.*, 498 U.S. at 58 (although indirect, state anti-subrogation law relates to ERISA plans). Because HMOs are the means chosen by the plans to provide health care benefits to their participants, the HMOs are, by statutory definition, an integral element of the plans that are protected by ERISA from state interference -- direct or indirect.

2. The 9% Assessment's Connection with ERISA Plans Is Substantial

While this purposeful interference with the choice of delivery systems and the above-described effects of the 9% assessment on ERISA plans are sufficient to demonstrate that the 9% assessment "relates to" ERISA plans, the record in this case confirms, in any event, that the 9% assessment has imposed substantial burdens on ERISA plans that purchase health care coverage from HMOs.

a. To begin with, the record reveals that, in the 1992-93 fiscal year alone, the 9% assessment was projected to raise approximately $30 million from all HMOs and the ERISA plans which they serve. (Bulgaro Aff. - Ct. of App. JA-1733.) In subsequent years, the number has increased by many millions more. As a practical matter, and as the State was undoubtedly aware, it is impossible for HMOs to absorb these additional costs. JA-265. HMOs generally set rates based on the projected costs of providing health care to their members. When the costs increase by virtue of an assessment, the costs are passed through in higher rates. While HMOs are statutorily required to maintain reserves, these reserves may be used only for unexpected costs and may not be used for day-to-day operational expenses. Moreover, if an HMO were to use reserves to pay the 9% assessment, the HMO would quickly exhaust its reserves and be forced into bankruptcy. In

short, the HMOs have no viable choice but to pass on the cost of the pool payments to their ERISA plan subscribers.

The record shows that, because inpatient hospital costs account for approximately 40% of total HMO expenditures, the 9% assessment has meant an increase of up to 3.5% for ERISA plans that obtain health coverage through HMOs. JA-265. Indeed, the New York State Insurance Department specifically cited the 9% assessment as the primary reason for allowing certain rate increases. JA-265-66; Exhibit "B" annexed to R. 32 (JA-19). Thus, there was no dispute before the district court that the cost of the 9% assessment had a substantial economic impact on ERISA plans.

Unlike the 13% differential, which ERISA plans can avoid by changing to different but arguably comparable indemnity insurance, ERISA plans purchasing coverage from an HMO do not have the same flexibility and cannot similarly avoid the economic effects of the 9% assessment. HMO coverage is not fungible. In contrast to indemnity insurance, which merely reimburses the policyholder after services have been rendered, HMOs provide access to care and provide a system of care that is unique to the HMOs. Physician-patient relationships exist between the members of an employee benefit plan and its HMO providers, which cannot be replicated by insurance companies. Moreover, the HMO almost certainly will have extensive and proprietary quality assurance programs in place that are unavailable from indemnity insurers and even from other HMOs. Thus, an ERISA plan cannot select alternative health coverage without disrupting the care that is being provided to its participants. Because this is not a feasible option for most ERISA plans, they have little choice but to pay the higher cost or restructure the terms of their plan.

b. In any event, the effects of the 9% assessment go well beyond increased costs. The 9% assessment actually interferes with the structure and provision of ERISA plan

benefits -- an interference that is more than sufficient to trigger the application of ERISA's preemption clause.

First, the 9% assessment interferes with the provision of services under employee benefit plans by seeking to force HMOs, and their affiliated health professionals, to serve Medicaid recipients at the expense of existing ERISA plan subscribers. Unlike indemnity insurance, HMOs must maintain an adequate network of physicians to serve their members. While HMOs generally seek to expand their membership, they do so in a planned way that includes network expansions. To the degree that the State forces an HMO to enroll Medicaid members based on arbitrary targets, and without concern as to the adequacy of the HMO's network, it disrupts the HMO's ability to serve its existing members. And to the extent that an HMO's membership, swelled by unanticipated Medicaid enrollment, exceeds the capacity of those facilities, it places a burden on existing members, who must now wait longer for non-acute care. While the HMO can address this problem by constructing new facilities and adding physicians to the network, this cannot be accomplished overnight and, in the interim, the burden on ERISA plan services is substantial.[3]

In addition, to the extent that HMOs cannot meet their Medicaid targets or choose not to do so in order not to impede the delivery of services to their ERISA plan subscribers, the HMOs must pass the increased costs arising from the 9% assessment on to their ERISA plan subscribers. ERISA plans must, in turn, either absorb the additional cost increase or restructure the terms of the plans to reduce the costs.

The most common way to restructure a plan is to reduce or eliminate supplemental benefits (such as dental care, vision

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[3] As noted above, this concern about capacity is not speculative. When the State amended the 9% assessment law in 1993, it provided for a reduction in an HMO's target if the HMO lacked sufficient capacity to provide adequate care to additional persons. 1993 N.Y. Laws ch. 731.

and pharmaceutical coverage) or to increase the co-payment that the plan participant must pay, including the co-payment for inpatient hospital services. In the district court, the State acknowledged in an affidavit that such plan restructuring could occur as a result of the 9% assessment (JA-157), and Judge Freeh found on the summary judgment record that:

> HMOs pass at least a portion of their increased costs on to the plans. In response to those increases, the plans may reduce the level of benefits or services offered rather than increase costs to participants -- a burden on plan administration which ERISA was designed to avoid.

Pet. App. A-74 (citations omitted). Thus, it is clear that the 9% assessment may result in fewer benefits, higher co-payments, or both, for ERISA plan participants -- a significant impact that surely establishes the requisite connection with ERISA plans. *See* discussion of *Metropolitan Life infra* p. 28-29.

The 9% assessment also interferes with the structure of ERISA plans in a more subtle, yet equally significant, way. Some ERISA plans are configured so that the employer will pay the full price of the lowest cost health coverage option, which is almost always an HMO; an employee that purchases a higher priced-option must pay the difference. This structure is intended to provide plan participants with at least one choice of coverage that does not require a contribution from the participant. When the price of the lowest cost option is increased, it may force the plan sponsor under the terms of the agreement to increase the contribution for every option in order to maintain full reimbursement for at least one option. Under this scenario, the 9% assessment option would affect not only the participants that opted for HMO coverage, but the entire benefits structure. In short, relative to the 13% and 11% surcharges, the 9% assessment is even more disruptive to the health care benefits provided to ERISA plans because it not only increases the cost and/or causes a reduction in

benefits, but also because it can interfere with an HMO's actual provision of health care to ERISA plan participants.

3. The Court's Cases Demonstrate That A State Law That Relates to ERISA Plans in this Manner Is Preempted

In enacting ERISA, Congress intended to bar intrusive state regulation that could result in the very disruption to the structure and administration of ERISA plans that is found here. *See Alessi*, 451 U.S. at 525. Contrary to petitioners' various arguments, no extension of the Court's prior interpretations of the statute is necessary to confirm this conclusion.

a. In *Metropolitan Life*, the Court was faced with a state statute that mandated that group health insurance policies include coverage of mental health care services. Significantly, the Court noted that the impact of the state law at issue did not fall directly on ERISA plans but rather affected such plans by virtue of their decision to obtain health care coverage through group health insurance contracts. 471 U.S. at 727-30, 739. Nevertheless, noting that the law "bears indirectly but substantially" on insured benefit plans, the Court ruled that the state law clearly "related to" ERISA plans. *Id.*

This case closely resembles the situation presented in *Metropolitan Life*. The state law at issue in *Metropolitan Life* sought to impose on group health policies the requirement -- and the cost -- of covering certain mental health conditions. Here, the 9% assessment has much the same purpose and effect: it seeks to increase the cost or force reductions and alterations in benefits. The 9% assessment is also similar to the statutory scheme in *Metropolitan Life* because both statutes impose burdens on the means through which ERISA plans obtain benefits -- in *Metropolitan Life* through a group health insurance policy and, here, through HMO coverage.

Indeed, it is important to recognize that, here, costs and benefits are flip sides of the same coin. As Judge Freeh found, to the extent that the law imposes additional costs on the

plans' choice of delivery systems, the plans must either absorb the costs or reduce their benefits. It is thus of no legal significance that the law at issue in *Metropolitan Life* mandated benefits rather than imposed a cost; as the Court held, the effect was the same. Similarly, in this case, while the law imposes a cost directly on the HMO delivery systems selected by ERISA plans, the effect can be, and often will be, to cause ERISA plans to reduce their benefits. Such a substantial impact on benefit delivery systems is more than sufficient to satisfy the "relate to" requirement.

b. Any doubt about this conclusion is resolved by the Court's decision in *Morales*. There, the Court was asked to review a preemption provision with "relate to" language identical to that found in ERISA. Adopting the same analytical approach that it has used in ERISA preemption cases, the Court engaged in a detailed analysis of the way in which the state regulation interfered with the functioning of the industry (commercial aviation) that was to be protected by preemption from state interference. Although the impact on the industry was indirect, the Court concluded that, "as an economic matter," the state law satisfied the "relate to" standard. 112 S.Ct. at 2039.

Morales demonstrates that the Court has not been deterred by the fact that a law may have only an economic impact on the subject protected by a federal preemption provision. In *Morales*, the Court was quite willing to find that a law which had an economic impact on a protected statutory subject related to such subject because the "deliberately expansive" nature of the "relate to" language could not be read to exclude pure economic impacts. 112 S. Ct. at 2037, 2039. The Court also acknowledged that a substantial economic impact triggered preemption because Congress intended the preemption provision to prevent the state from enacting laws that would interfere with the free market in the subject area of the statute -- in this case, the marketplace of employee benefits and, in *Morales*, the marketplace of air fares. *Id.* In short, preemption of the 9% assessment is not

only compelled by ERISA's text and structure, it also is wholly consistent with the Court's prior decisions.

C. Petitioners Offer No Sound Reason For Finding that the 9% Assessment Is Not Preempted

In seeking to defend their proposed departure from the statutory text and the Court's interpretations thereof, petitioners offer a series of interpretive and policy arguments that they claim militate against preemption. Most of these arguments are, on their face, directed at the 13% and 11% surcharges and are not even applicable to the 9% assessment. And, in any event, they do not alter the conclusion that ERISA preempts the 9% assessment.

1. The 9% Assessment Does Not Implicate A State's Regulation of Its Hospital Reimbursement System

The petitioners and their amici raise a Chicken Little-esque cry about the potential consequences of upholding the court of appeals' decision. (Blues Br. at 21; HANYS Br. at 18, 23-25; N.Y. Br. at 18; Amicus Curiae Brief of American Hospital Association et al. ["AHA Br."] at 21-25; Amicus Curiae Brief of the National Governors' Association et al. ["NGA Br."] at 10-11; Amicus Curiae Brief of the States of Minnesota et al. ["States Br."] at 6-11.) They claim that preemption might preclude a state from regulating in any fashion its hospital reimbursement system. This claim is unfounded.

The 9% assessment is totally unrelated to New York's hospital reimbursement system. The 9% assessment is measured based on the HMO's aggregate inpatient hospital costs, but otherwise has no connection to hospital rates or services. As discussed above, the funds from the 9% assessment go entirely to the State's general fund, not to the hospitals. Thus, preemption of the 9% assessment will not in any way affect the State's ability to regulate its hospital reimbursement system.

Moreover, unlike a neutral assessment on hospital rates that applies to all payors, the assessments at issue in this case are intended to affect plan choice -- a point that the State has conceded. (N.Y. Br. at 27-29.) Thus, the assessments -- and particularly the 9% assessment -- simply do not raise the questions presented by petitioners and their amici as to (1) whether all state regulation of hospital rates is preempted (N.Y. Br. at 24-25; AHA Br. at 21-25; States Br. at 7-11); (2) whether a state may establish a DRG system of hospital reimbursement (NGA Br. at 17); (3) whether a state may impose a neutral assessment to fund bad debt and charity care; or (4) whether a state may regulate the working conditions of medical personnel or hospital sanitary conditions (N.Y. Br. at 24-25; Blues Br. at 21; HANYS Br. at 24.) As the amicus brief submitted by the states of Minnesota, Connecticut, Maryland, et al. recognizes, some states -- Maryland is cited as an example -- impose reimbursement "uniformly among all payors, including Medicare and Medicaid." (States Br. at 27.) In contrast, New York's hodge-podge system of regulation targets various payors of hospital rates, and it is this targeting of the means through which benefits are delivered that results in preemption here.

Indeed, in *Morales*, 112 S. Ct. at 2040, the Court rejected the very type of "sky is falling" argument advanced by petitioners and their amici here. In *Morales*, the state contended that preemption of certain advertising guidelines would inevitably lead to preemption of state laws against gambling and prostitution (as applied to airlines). The Court rejected this argument, noting that the connection between those practices and the "rates, routes and services" enumerated in the federal statute would be far more tenuous than the situation then before the Court. As the Court recognized in *Morales*, a recitation of petitioners' fears does not warrant the imposition of a new preemption standard, particularly where, as here, the state regulation so clearly "relates to" ERISA plans. *Id.* at 2040 ("In this case, as in *Shaw*, '[t]he present litigation plainly does not present a

borderline question, and we express no views about where it would be appropriate to draw the line.' ")(quoting *Shaw*, 463 U.S. at 100); *accord*, *Alessi*, 451 U.S. at 525 ("We need not determine the outer bounds of ERISA's pre-emptive language to find this New Jersey provision an impermissible intrusion on the federal regulatory scheme.").

2. The 9% Assessment Does Not Have A Remote or Tenuous Relationship to ERISA Plans, and Preemption Promotes the Purposes of ERISA

Petitioners next attempt to remove the 9% assessment -- and the other surcharges as well -- from the ambit of ERISA preemption by arguing that the assessment is a law of general application that has only a "remote and tenuous" relationship to ERISA plans. (Blues Br. at 20-22; HANYS Br. at 15-23; N.Y. Br. at 13-18.) However, this argument, in all its permutations, ignores the plain language of the statute, as well as the Court's prior decisions.

a. First, contrary to petitioners' assertions, the 9% assessment is not a law of general application. The 9% assessment is far different from a sales tax, utility tax or other statute that applies not only to health care entities but also to numerous and diverse segments of society. Here, the law applies only within the health care benefits area and, indeed, only to one of the means by which ERISA plans deliver benefits to their participants. Moreover, because the 9% assessment exempts Medicaid from its reach, the law quite blatantly discriminates between ERISA plan subscribers and non-ERISA plan subscribers.

In any event, contrary to petitioners' assertions, this Court has already ruled that even laws of general applicability may "relate to" benefit plans. In *Morales*, the Court explicitly rejected the argument that the preemption clause contained in the Airline Deregulation Act of 1978 preempted only state laws specifically addressed to the airline industry, but not laws of general applicability. The Court stated that: "Besides

creating an utterly irrational loophole (there is little reason why state impairment of the federal scheme should be deemed acceptable so long as it is effected by the particularized application of a general statute), this notion similarly ignores the sweep of the 'relating to' language." Morales, 112 S. Ct. at 2038.

Thus, petitioners' reliance on *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), is completely misplaced. In *Mackey*, the Court addressed a garnishment statute that applied to ERISA plans as well as to every other kind of commercial entity. The economic impact of the garnishment statute at issue in *Mackey* fell equally on all commercial entities and did not single out for disparate treatment the means by which ERISA plans deliver benefits. Moreover, the statutory structure of ERISA contemplated that garnishment actions would not constitute unreasonable interference with the delivery of benefits by ERISA plans. In contrast, the 9% assessment focuses exclusively on the means by which health care benefits are delivered -- a subject uniquely protected by ERISA -- and nothing in ERISA suggests an intent by Congress to allow states to interfere so unreasonably with ERISA plans' choice of health care delivery systems. Whether a statute of general application or not, the 9% assessment plainly "relates to" ERISA plans.

b. The petitioners similarly err in suggesting that a law of indirect economic impact that only "influences" plan choice falls outside of the scope of ERISA preemption. (N.Y. Br. at 27-29; HANYS Br. at 35-37.) This suggestion fails for a number of reasons.

First, the argument confuses general laws that solely affect the price of a product or service that ERISA plans might purchase (*e.g.*, rent for a leasehold) with a law that attempts to direct a plan's choice of a benefits delivery system, such as that at issue here. As the Secretary of Labor argued to the court of appeals, the 9% assessment regulates the means by which benefits are provided and seeks to dictate a fundamental choice that ERISA specifically allows ERISA

plans to make free from state interference. Thus, contrary to petitioners' suggestions, the 9% assessment is easily distinguished from other state laws that may simply have an indirect economic impact on ERISA plans by regulating goods and services that ERISA plans purchase, but that are not identified by ERISA as constituting an integral component of the provision of benefits by ERISA plans.

Second, the petitioners also err in arguing that state laws that regulate by incentives or inducements, rather than by mandates, cannot "relate to" ERISA benefit plans. Even putting aside the fact that the 9% assessment is a virtual mandate (because ERISA plans cannot easily transfer from HMO coverage to indemnity coverage), petitioners' suggestion that there is "a legally significant distinction between influencing plan choice and mandating plan conduct" (N.Y. Br. at 27) misreads ERISA's preemption provision and subverts its purposes. HANYS' argument that barring "States from using economic incentives to encourage consumers (including ERISA plans) to make certain choices would deprive [states] of an important form of regulation" (HANYS Br. at 37, n.31), is equally misplaced. The broad language of the preemption provision, the broad definition of "employee benefit plan" and Congress' stated intent to leave to plans the choice of how they would provide benefits all make clear that ERISA bars the states from regulating -- whether through incentives or mandates -- the means by which plans deliver benefits to their participants. State intervention by regulatory incentive offends Congress' intention to maintain a free market in the area of employee benefits as decidedly as state intervention by mandate.

Indeed, this Court has already so concluded. In *Metropolitan Life*, the Court recognized that ERISA plans could avoid the inclusion of mandated benefits in insurance contracts by becoming self-insured. 471 U.S. at 747. Nevertheless, the Court easily found that the statute "related to" ERISA plans. The ERISA plans in *Metropolitan Life* also

could have avoided the burden of the mandate by discontinuing health benefits altogether. Indeed, as the cost of health care increases, particularly when burdened by state-imposed assessments or mandated benefits, many small businesses opt, reluctantly, to discontinue health care coverage. It was precisely because Congress understood that state interference with the market of health care benefits could result in fewer benefits for plan participants that Congress enacted ERISA's sweeping preemption clause.

Similarly, in *Morales*, the state argued that its law regulating air fare advertising did not improperly compel or restrict airline advertising. But the Court again rejected this argument as a limitation on preemption, noting that the law nevertheless had a significant impact on the area preempted by the statute. 112 S.Ct. at 2040.

Moreover, in analogous areas, the Court has had little difficulty recognizing and rejecting backdoor attempts by states to regulate in areas that Congress has exempted from state regulation. For example, under the National Labor Relations Act, 29 U.S.C. § 151 *et seq.* (1973) ("NLRA"), Congress largely displaced state regulation of industrial relations. *Wisconsin Dep't of Indus., Labor and Human Relations v. Gould, Inc.*, 475 U.S. 282, 286 (1986). Thus, when states have attempted to interfere with the marketplace dynamic that was protected from state regulation by the NLRA (as well as by ERISA), the Court has not hesitated to find such interference preempted.

For example, in *Gould*, a state debarment statute forbid state procurement agents from purchasing any product sold or manufactured by a person found by the National Labor Relations Board to have violated the NLRA in three separate cases within a five-year period. The state asserted that the statute escaped preemption because it was not actually regulating any activity governed by the NLRA. 475 U.S. at 287. Rejecting the state's contention as a "distinction without

a difference", the Court held that the statute was indeed preempted by the NLRA. Id. (emphasis added).

Similarly, in *Golden State Transit Corp. v. City of Los Angeles*, 475 U.S. 608, 614-15 (1986), the City of Los Angeles attempted to use "economic weapons" to influence the resolution of a labor dispute. Specifically, the City attempted to condition renewal of a franchise on a company's settlement of a labor dispute. The Court held that the City could not properly do so, noting that, while the NLRA established a framework for negotiations, it left the outcome of the bargaining process to the parties, and the City was not permitted to attempt to influence that outcome. *Id.* at 615-18. Thus, the Court held that the City's efforts to induce resolution of a dispute -- by incentive rather than by imposition of contract terms -- was preempted.

The issue presented here is analytically the same as those presented in *Gould* and *Golden State Transit*. Petitioners' attempt to draw a line between mandating and influencing plan choice is the very type of "distinction without a difference" that the Court has rejected. As Congress did in the NLRA, in ERISA it established a framework for creating and maintaining employee benefit plans. Congress recognized that there would be tradeoffs in that process but chose to leave the results of the process to the parties rather than to mandate benefits. And, in contrast to the NLRA, which does not even include an express preemption clause, ERISA, by its broad preemption provision, protects the results of this process from state interference. The 9% assessment is preempted by this provision as surely as the state-created "economic weapons" at issue in *Gould* and *Golden State Transit*.

c. Finally, petitioners and amici err in suggesting that the 9% assessment should not be preempted because it does not impede the interstate operation of ERISA plans. (N.Y. Br. at 21-23; AHA Br. 5-6; Amicus Curiae Brief of United States ["U.S. Br."] at 13.) Not only does this suggestion ignore the reach of the "relate to" standard, which is not limited to laws

that impede the interstate operation of ERISA plans, but it self-servingly ignores the impediments that the 9% assessment imposes on multi-state ERISA plans.

Although many national ERISA plans offer employees a choice between indemnity coverage (often one national plan) and a number of regional or local HMOs, it is common for ERISA plans to encourage employees to enroll in HMOs. ERISA plans encourage managed care not just because it almost always is less expensive, but also because it emphasizes maintaining health rather than treating illness and because its quality can be measured and compared.

ERISA plans encourage this enrollment pattern largely through pricing. Under the structure of many plans, the employer contributes a flat amount toward health care coverage, which often is just enough to cover most, if not all, of the lowest price option: the HMO. Those employees that want indemnity coverage must pay more. Thus, while the overall cost of the HMO may vary from state to state, the HMO remains the benchmark price in the benefits plan in every state.

This structure encourages uniform, multi-state administration of the ERISA plan and its policy choices. If an employee is transferred from one state to another, the employee will face different health coverage choices but an identical benefit structure: the HMO will be the lowest priced option.

The 9% assessment interferes with these decisions. Because it is imposed only on HMOs, the 9% "unlevels the playing field" in comparison to indemnity insurance. HMO coverage, which had been less expensive, is suddenly made relatively more expensive, thereby causing some employees to gravitate to indemnity coverage. This undermines the choice that the ERISA plan made to encourage employees in various states to enroll in a managed care delivery system and denies the ERISA plan the very efficiency and quality assurance which influenced the plans' delivery system selection in the first instance.

If every state were allowed to impose similar discriminatory assessments, it would wreak havoc with the multi-state operation of ERISA plans. Under such circumstances, multi-state ERISA plans might decide to offer only fee-for-service indemnity coverage because there would be no certainty as to the relative pricing of the two systems of coverage. This is the precise type of state interference with multi-state benefit plan decisions that the preemption clause was intended to bar. As this Court has said,

> To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.

FMC Corp., 498 U.S. at 60.

3. Limitations on ERISA's Preemption Clause Are Best Left to Congress

Although the petitioners and their amici acknowledge that the language of ERISA's preemption clause is expansive, (HANYS Br. at 15; N.Y. Br. at 13; U.S. Br. at 10), they nevertheless urge this Court to constrain the language by imposing new interpretive boundaries on its reach. However, the imposition of such new limitations is more properly the role of Congress.

When ERISA's preemption provision was originally drafted, it expressly referenced particular areas of state regulation that were to be preempted by the federal scheme. *Pilot Life*, 481 U.S. at 46; *Shaw*, 463 U.S. at 98-99. Later, a conference committee convened and omitted all references to particular areas of regulation, opting instead for the broader "relate to" language. *Id.* The conference committee did so in the face of objections by the Administration that the preemption provisions of the House and Senate bills were "extremely vague" and "too broad", respectively. 3 Legislative History of the Employee Retirement Income Security Act of 1974 ("Legislative History") (Comm. Print

1976) at 4357; *Administrative Recommendations to the House and Senate Conferees on H.R. 2 to Provide for Pension Reform* (April 1974), *reprinted in* 3 *Legislative History* 5047, 5145-5146. However, having rejected a more tailored preemption clause in favor of broad and open-ended language, it is clear that only Congress can properly impose limitations of the type that petitioners seek.

In fact, in the past, Congress has imposed such limitations. In 1981, the Court summarily affirmed a decision that ERISA preempted Hawaii's Prepaid Health Care Act, which required workers in the state to be covered by a comprehensive prepaid heath care plan. *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), *aff'd*, 663 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). Health care regulation in Hawaii did not crumble as a result of the Court's ruling. Instead, Congress intervened and amended ERISA's preemption provision to expressly exclude the Hawaii Act from preemption. *See* 29 U.S.C. § 1144(b)(5)(B)(ii). Notably, Congress did not amend the savings clause to provide an exemption from preemption for state health care or health insurance laws generally. Nor did it exempt from preemption amendments to the Hawaii Act enacted after September 2, 1974.

Moreover, the Court has previously recognized that, where concern is raised about the scope or application of a federal statute, it is appropriate to defer to Congress the task of remedying whatever statutory defect is perceived to exist. For example, in *Sedima v. Imrex Co.*, 473 U.S. 479 (1985), the court of appeals, concerned about the misuse of civil RICO actions by private plaintiffs, construed a provision of the Racketeer Influenced and Corrupt Organizations Act to permit private actions only against defendants who had been convicted on criminal charges and only where there had occurred a specific "racketeering injury." This Court rejected the court of appeals' limitation, noting that the fact that a statute is applied in situations not expressly contemplated by Congress does not necessarily mean that the statute is

ambiguous. Instead, "[i]t demonstrates breadth." *Id.* at 499. This Court also noted that the defect, if it was a defect, "is inherent in the statute as written, and its correction must lie with Congress." *Id.*; *see Metropolitan Life*, 471 U.S. at 747 (Court recognized that its decision might create "disuniformities" but stated that "[a]rguments as to the wisdom of these policy choices must be directed at Congress.").

This is not a case where Congress is unaware of the issue or has proven itself unable to act. To the contrary, the impact of the ERISA preemption clause on both state and federal efforts to reform health care has been a major subject of discussion during the past few years and Congress is actively considering various proposals that address the issue. Moreover, in the past, Congress carved out of the preemption clause various areas for state regulation. Under such circumstances, this Court should decline petitioners' invitation to begin constructing artificial lines constraining the preemption clause, particularly in a case such as this where the law at issue is deliberately intended to influence ERISA plan choice.

D. A Determination that the 9% Assessment Relates to ERISA Plans is Dispositive of This Aspect of the Case

If the Court agrees with us that the 9% assessment relates to ERISA plans, then the 9% assessment is preempted. Petitioners have never asserted that the 9% assessment falls within ERISA's insurance savings clause. Nor do petitioners take such a position before this Court.[4]

While the Court is being asked to resolve the question of whether HMOs are in the business of insurance for purposes

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[4] Although in its brief supporting the petitions for a writ of certiorari, the United States suggested that the 9% assessment might fall within the insurance savings clause, (U.S. Br. in Support of Petitions at 16-17), the Government now concedes that this issue has not been raised on appeal. (U.S. Br. at 19, n. 8.)

of the insurance savings clause, this inquiry -- which the HMOs address below -- arises in connection with the *13% differential*. In ruling that the 13% differential did not fall within the insurance savings clause, the district court noted that the 13% differential applied to a variety of payors other than insurance companies and cited HMOs as one such example. Thus, the only reason that the issue whether HMOs are in the business of insurance is before the Court is to determine the degree to which the 13% hospital differential reaches beyond insurers -- an inquiry which may involve, but need not turn on, the status of HMOs.

The outcome of this inquiry does not, however, affect the conclusion that the 9% assessment is preempted. To the contrary, because petitioners concede that the insurance savings clause does not apply to the 9% assessment, the 9% assessment should be held preempted if the Court agrees that it "relates to" ERISA plans.

II. HMOs ARE NOT ENTITIES WITHIN THE INSURANCE INDUSTRY

As discussed above, petitioners acknowledge that, if the 9% assessment is found to "relate to" employee benefit plans, it cannot be saved from preemption as a law regulating the business of insurance. Nonetheless, for purposes of determining whether the 13% surcharge is directed solely at entities in the insurance industry, and can thereby be saved as a law regulating the business of insurance, petitioners assert that the court of appeals erred in concluding that HMOs are not insurers as a matter of law. Because that issue is of general importance to us, we address it here.

A. At the outset, we note that there is an inherent tension between the expansive language of ERISA's preemption clause and the limiting language of the insurance savings clause: the more broadly that the insurance savings clause language is construed, the more it cuts into the explicitly expansive language of the preemption clause. Indeed, the court of appeals recognized that

> Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans . . . and installed the saving clause to preserve only those state laws *precisely directed at the insurance business*. The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.

JA-58 (emphasis added and citations omitted). Accordingly, the Court has determined that the insurance savings clause is narrower than the preemption and deemer clauses. *See, e.g.*, *Shaw*, 463 U.S. at 104 (comparing ERISA's "all-inclusive" preemption provision with its "narrow, specific exceptions" to that provision); *FMC Corp.*, 498 U.S. at 64 (rejecting a restricted reading of the deemer clause).

In determining whether a practice falls within the scope of the insurance savings clause, the Court has traditionally first applied a common-sense test and then looked to the three-part test developed in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982):

> first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Id.; see also Metropolitan Life, 471 U.S. at 743.

In their decisions below, the district court and court of appeals ruled that the 13% surcharge failed the third prong of the *Pireno* test in part because HMOs, as a matter of law, are not entities within the insurance industry. These decisions clearly conform with a common sense understanding of the function and structure of HMOs, as well as with the legally relevant characterization of HMOs under federal and state laws.

B. In determining the scope of both the insurance savings clause and the third prong of the *Pireno* test, it is instructive to return to the text of ERISA. In defining the term "employee benefit plan," Congress clearly recognized that there were ways that employee benefit plans could obtain coverage other than through insurance:

> any plan, fund or program . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical or hospital care or benefits . . . .

29 U.S.C. § 1002(1) (emphasis added). There was little reason for Congress to include the words "or otherwise" if Congress did not recognize that there were ways, other than through insurance, to provide health care benefits.

This language is particularly relevant in view of the fact that one year earlier, Congress had debated and enacted the HMO Act. The language and legislative history of the HMO Act make it clear that Congress did not view HMOs as insurers. The HMO Act was intended to encourage the growth of HMOs and stemmed from Congress' recognition that HMOs offer an alternative to fee-for-service indemnity insurance:

> First, and most important, the development of HMOs throughout the country will provide consumers with the opportunity to choose the manner in which they will pay for and receive health care services. At the present time, no such choice exists in most parts of the United States. Therefore, in excess of 95% of all health services are rendered on a fee-for-service basis. The goal of this legislation is to increase the options from the point of view of the consumer.

S. Rep. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3039-40. In order to encourage

such growth, Congress specifically preempted five types of state laws that were inhibiting the growth of HMOs, including state laws that "require[d] that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency . . . ." 42 U.S.C. § 300e-10(a)(1)(D). The Senate Conference Committee considering the original bill stated that HMOs "should not be required to submit to regulations as an insurer of health care services . . . . Such restrictions would be unduly restrictive, onerous, and not within the spirit of this legislation." S. Rep. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3058. Because it made little sense for Congress to exempt HMOs from state insurance regulations if Congress believed that HMOs were insurers, the inevitable conclusion is that Congress intended that HMOs not be treated as insurers.

The HMO Act simply reflected what was and is the main distinction between HMOs and insurers. Unlike insurance companies, HMOs are integrated systems of care that arrange for, or actually provide, medical services to HMO members. Many HMOs have health centers containing primary care and specialty care physicians, diagnostic services, laboratories and pharmacies. Other HMOs have extensive networks of physicians that are part of a comprehensive delivery system of medical services, and that are generally accountable to the HMO. In either case, HMOs are clearly distinguishable from the traditional insurer that simply indemnifies individuals for claims incurred.

Moreover, HMOs provide this care through a unique set of rules and practices that have no analogue in the world of insurance. Under an HMO managed care system, an HMO member must select a primary care physician from the HMO's staff or network, who, in effect, manages the care for that individual. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(b),(c). If specialty care is needed, the member must generally obtain a referral from the primary care physician and usually is referred to other physicians who are on the

staff, or in the network, of the HMO. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(c),(d). JA-263. In the case of a member with a serious illness, a medical director will work with the primary care physician, the specialty care physician, a hospital and others to insure that the care being provided is coordinated and that there is a comprehensive treatment plan.

While HMOs must accept and community rate all groups and individuals, they are able to limit the risk that arises from such practices by maintaining the health of their members and providing care in the most efficient manner. In contrast, indemnity insurance companies limit risk by underwriting practices that exclude individuals with particular high risk conditions or propensities and by pricing premiums based on the experience of the individual or the group.

HMOs also differ from insurers in that HMOs have the financial incentive and statutory responsibility to maintain quality assurance programs. *See, e.g.*, N.Y. Comp. Codes R. & Regs. tit. 10, § 98.12. In New York, HMOs are responsible for credentialing physicians, maintaining continuity of care, reviewing charts and overseeing the care that is provided. HMOs also provide formal grievance procedures to permit members the opportunity to challenge decisions with which they disagree. N.Y. Pub. Health Law § 4403(1)(g); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.14. In contrast, traditional indemnity insurers merely reimburse policyholders' claims for care provided by independent medical professionals and institutions.

It was these very differences that caused Congress to encourage the growth of HMOs through the HMO Act, and even petitioners acknowledge (HANYS Br. at 21) that Congress was mindful of the HMO Act -- and its preemption clause -- when it enacted ERISA the following year. In this context, the specific acknowledgment in ERISA that health care benefits could be provided in ways other than through insurance constitutes a clear recognition by Congress that

HMOs were (and still are) a growing presence among employee benefit plans.

Significantly, however, the language of the savings clause is limited to "insurance" -- a term that had specific and limited meaning to Congress based not only on the common understanding of the term but also on the traditional deference that Congress had provided to state regulation of insurance. *See, e.g.*, McCarran-Ferguson Act, 15 U.S.C. § 1012(a). Yet there is no mention in ERISA of exempting from preemption state regulation of other methods of providing health care benefits. Accordingly, the text and legislative history of ERISA strongly support the view that Congress did not view HMOs as entities within the insurance industry or as entities falling within one of the exemptions to the preemption clause.

Moreover, it is instructive that, under New York State law, HMOs are not insurers. Section 1109 (a) of the Insurance Law explicitly exempts HMOs from insurance licensing requirements:

> An organization complying with the provisions of article forty-four of the public health law may operate without being licensed under this chapter and without being subject to any provisions of this chapter, except to the extent that such organization must comply with the provisions of this chapter by virtue of such article.

N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1994). Although the Blues make much of the fact that this is only a "limited exemption" from state insurance regulation (Blues Br. at 43), this is a distinction without a difference. Under state law, an HMO's freedom from insurance regulation is limited only to the extent that the Department of Health mandates that the HMO comply with certain provisions of the insurance law or to the extent that the HMO is not certified pursuant to Article 44 of the Public Heath Law. As each respondent HMO is certified under Article 44, the latter limitation does not apply here.

Moreover, the mere fact that the Department of Health may deem it appropriate or expedient to have HMOs comply with certain provisions of the insurance law does not convert an otherwise distinct entity into an insurance company. As the court of appeals found:

> While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). *These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs ... do not engage in the 'business of insurance' as a matter of law."*

JA-57, n. 5 (emphasis added and citation omitted). Indeed, the Insurance Law expressly excludes from the definition of "authorized insurer" any organization not required to be licensed as such. N.Y. Ins. Law § 107(10) (McKinney 1985).

C. Numerous cases have focused on the distinctions between HMOs and indemnity insurers to hold that HMOs are not in the business of insurance. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 247 (D.C. Cir. 1939) (consumer cooperative that provided medical services and supplies to members for a fixed premium differs from indemnity companies in that indemnity companies "are concerned primarily, if not exclusively, with risk . . . . On the other hand, the cooperative is concerned principally with getting service rendered to its members and

doing so at lower prices made possible by quantity purchasing and economies in operation") (footnotes omitted and cited with approval in *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205, 228 (1979)); *accord, O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) ("... the fact that [an HMO] may be subject to the same laws as state insurance companies does not mean that it is in the 'business of insurance' for the purpose of the ERISA savings clause."); *Pomeroy v. Johns Hopkins Medical Serv., Inc.*, No. MJG-94-2236, 1994 U.S. Dist. LEXIS 16418 at *17 (D. Md. Oct. 17, 1994) (HMOs are not in the "business of insurance"); *Dearmas v. Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993) (an HMO is not an insurance company); *McManus v. Travelers Health Network*, 742 F. Supp. 377 (W.D. Tex. 1990) (HMOs and Texas HMO Act do not fall within the savings clause); *In re Family Health Serv.*, 101 B.R. 618 (C.D. Cal 1989) (although statutes regulating HMOs are found in the state insurance code, HMOs are not insurance companies because the HMOs' ability to provide medical services, manage care and contain costs distinguishes them from insurance companies).

D. Thus, the text of ERISA, the text and legislative history of the HMO Act, a common sense understanding of the differences between HMOs and insurers and New York State's own laws make clear that HMOs are not "entities within the insurance industry." Petitioners' argument to the contrary is unfounded.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,
Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,
Respondents.

(Caption continued on inside front cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

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MARIO M. CUOMO, ET AL.,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

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REPLY BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

Preliminary Statement

With the principal briefs lodged, key matters stand beyond dispute. First, New York's regulatory scheme treats ERISA plans no differently from any other payors for hospital services. ERISA plans are free, as are any other persons, to choose Blue Cross, commercial insurance, HMOs or self-funding to provide benefits. The fact is that the Plans cover a high percentage of the ERISA plans in New York State. In any event, the challenged statutes apply across the board to all payors for hospital services without regard to whether the hospital patient is a participant or beneficiary in an ERISA plan. In short, the regulatory scheme at bar is ERISA neutral.

Second, respondents make much of differences in hospital service payment costs between commercial insurers and the Plans stemming from the differentials. But what counts is—not differences in costs—but differences in premiums, and the record is barren of any evidence of the Plans charging lower premiums than the commercials. Just to the contrary, nowhere challenged is the New York Deputy Superintendent of Insurance's showing that even after the 13% differential was enacted the Plans lost substantial numbers of subscribers because "the better risks mov[ed] to commercial insurers who offer lower premiums." (JA-168.)

Third, respondents agree that even absent state regulation of hospital rates generally, or the differentials in particular, there would be no national uniformity in hospital rates or methods of billing.

Fourth, none dispute that "the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers [and that m]ost high risk policyholders . . . are insured under the Blues." (JA-58.) And though respondents labor mightily to establish the point, not disputed is that one purpose of the challenged differentials is to help the Plans cover added costs, which they alone bear, of engaging in publicly responsible activities. By helping to defray overall costs, and thus alleviating the need for otherwise required rate increases, the differentials help the Plans retain sufficiently large numbers of good risks in their subscriber base to promote the affordability of premiums.

Summary of Argument

What remains in dispute is (1) whether the means chosen by New York State to achieve its objectives of hospital cost control and insurance regulation impermissibly interfere with the choices ERISA plans must make and thus "relate to" such plans. State statutes that create differences in costs, even differences in costs that may make one route for providing hospital coverage less expensive than another, do not mandate that particular benefits be provided or require ERISA plans to structure or administer their plans in any particular fashion. Thus, they do not create the type of interference necessary to trigger preemption. Nor can the influence of the differentials be viewed, as respondents urge, in a vacuum without considering the variety of other factors in the regulatory scheme that impact cost and choice along with the numerous cost and non-cost factors assessed by ERISA plans in determining how best to provide coverage.[1] In enacting ERISA, Congress

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[1] For example, it is uncontroverted that prior to the statutorily prescribed differential, the Plans' differentials ranged between 25% to 40% as a result of hospital by hospital negotiation. (JA-162, 187.) Indeed, as an affidavit submitted by respondents makes clear, one purpose of establishing a 13% statutory differential was to reduce the dif-

surely did not intend to preempt any and all laws which may to any degree influence the choices ERISA plans make in providing coverage.

Arguing to the contrary, Travelers incorrectly asserts that "[p]etitioners' entire argument rests upon their attempt to manufacture a distinct ERISA preemption standard applicable to 'laws of general applicability.' " (Brief for Respondents The Travelers Insurance Company, *et al.* ("Travelers Br.") at 13.)[2] Here, the Plans argue that not only are the challenged differentials laws of general applicability, but also that they do not dictate or unduly restrict choices regarding the structure or administration of plans. Nor do they interfere with national uniformity of plan administration. After, just like before, New York adopted its insurance regulatory scheme, hospital costs and charges not only varied hospital to hospital, but also state to state. Finally, petitioners simply do not urge the Court to narrow the scope of ERISA preemption; rather, they contend that a finding that the challenged differentials are not preempted is fully consistent with the prior decisions of this Court.

(2) Also in dispute is whether the 13% and 11% differentials regulate insurance. However, by going out of their way to argue that the purpose of the differentials is to influence the choice regarding insurance coverage, respondents and *amici* disable their challenge to petitioners' argument that the laws regulate insurance. Furthermore, Travelers' rigid application of the McCarran-Ferguson Act criteria cannot be squared with the broader language of ERISA's saving clause. And ERISA's deemer clause does not exempt self-insured

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ference in rates paid by charge payors, such as commercial insurers, and the Plans. (JA-275-76, 243-48.)

[2] *See* Brief For Respondents New York State Health Maintenance Organization Conference *et al.* ("HMOs Br.") at 32; Brief for NYSA-ILA Welfare Fund, Local No. 807 Labor-Management Health Fund, *et al.* as *Amici Curiae* in Support of Respondents ("NYSA-ILA Br.") at 5 (similarly misconstruing the petitioners' arguments).

funds from the 13% differential because New York's insurance regulatory scheme does not deem self-funded plans to be insurers.

Argument

I.

THE CHALLENGED STATUTES DO NOT RELATE TO ERISA PLANS

A. The Challenged Differentials Do Not Impermissibly Interfere with the Choices ERISA Plans Make in Providing Benefits

Apparently conceding that an indirect economic impact is insufficient to warrant preemption, respondents focus on their contention that the differentials "purposefully discriminate among benefit payors *in order to influence the choices made by ERISA plans*" and maintain that petitioners concede this point. (Travelers Br. at 10, 13, 21-22 and n.11 (emphasis omitted and emphasis added).) This is simply wrong: Influencing ERISA plan choice (as distinct from the choice of any other individual or group regarding the purchase of healthcare coverage) was not the purpose of the differentials.[3] The challenged statutes do not mandate that the 13% differential be passed through to the insurers' customer and be fully reflected in the premiums charged. Rather, the discount

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[3] Travelers inaccurately distinguishes *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), on the ground that, unlike New York's scheme, the "New Jersey law was [not] designed to influence ERISA plan choice regarding particular forms of health coverage." (Travelers Br. at 22 n.11.) However, in both *United Wire* and this action, plaintiffs challenged differentials in the hospital rate applicable to particular payors, not the underlying DRG rate. *See United Wire*, 995 F.2d at 1189-90. Since not all payors could qualify for the differentials in New Jersey, the allegedly discriminatory impact upon plan choice was precisely the same as in this action.

afforded by the differentials helps offset the higher claims and other costs that the Plans incur by engaging in publicly responsible activities and thus fosters the provision of widespread affordable health insurance. (A-101; JA-188, 153, 165-66.)[4] The differentials simply enable the Plans to charge lower premium rates than would otherwise be possible. The purpose of the differentials is not, as respondents contend, to make the Plans' premiums cheaper than respondents.[5]

Furthermore, respondents' support for the supposed discriminatory effect of the differentials consists solely of the

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[4] Respondents' attack upon the wisdom or effectiveness of the challenged differentials can have no bearing upon the matters before this Court. (*See* Travelers Br. at 6 n.5.) In *Stuart Circle Hospital Corp. v. Aetna Health Management Corp.*, 995 F.2d 500, 504-05 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993), in considering whether a state's preferred provider law was saved, the court noted that the "legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision is a concern of the legislature, not the judiciary." Indeed, in construing the McCarran-Ferguson Act, courts have repeatedly emphasized that it is irrelevant whether a different regulation would have been wiser or would have better served the state's ends. *See Lawyers Title Co. v. St. Paul Title Insurance Corp.*, 526 F.2d 795, 797 (8th Cir. 1975); *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

[5] Respondents erroneously suggest that except for the differentials, New York's DRG system would be "evenhanded." (Travelers Br. at 2.) By focusing only upon the single component of New York's comprehensive hospital rate-setting and insurance regulatory scheme which they dislike, respondents ignore the numerous factors within the scheme that favor them. Although the differentials favor the Plans, the Plans are disfavored by many other aspects of New York's system. For example, the Plans are subject to investment and other regulatory restrictions not applicable to commercial insurers. Since commercial insurers have greater freedom in investing, they have a greater potential return. And although the HMOs claim that the 9% differential discriminates against them, they are favored as the only payor permitted to negotiate rates. Thus, in evaluating the differentials' alleged discriminatory impact, they must be viewed in the larger context of the regulatory scheme as a whole—not with respondents' tunnel vision.

undisputed fact that most people obtain coverage for hospital services through ERISA plans and self-evident propositions regarding the economic, but not discriminatory, impact of the differentials. Travelers points to the unremarkable facts that the differentials represent 2% to 5% of the cost of providing hospital and medical coverage and that increased costs may result in premium increases. (Travelers Br. at 5.) Correspondingly, the HMOs claim an "increase of up to 3.5% in total costs for most HMOs." (HMOs Br. at 9.)[6] But such differences in costs provide no support for respondents' position. What counts to consumers, including employee benefit plans, is differences in premiums.

However, the Record may be searched in vain for a shred of evidence that the differentials have had an "inexorable effect of tilting ERISA plans away from the disfavored benefit payors and toward the Blues." (Travelers Br. at 16-17.) In fact, the Record reveals that because the Plans provide coverage to the State's poorer risks, the commercial insurers have been able to offer more competitive rates than the Plans, despite payment of the differentials. These more competitive rates have caused the Plans to continue to lose substantial numbers of subscribers from their small group pools. Obviously, without the differential the losses from the Plans' pools would be still greater.[7]

In any event, respondents' discrimination argument cannot withstand analysis. Under respondents' theory, any state law

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[6] This is the entirety of the economic impact in the Record upon which the Second Circuit based its holding that "[t]he surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of healthcare benefits." (JA-53.)

[7] As noted by the State's Insurance Department, for the five-year period from 1983—the year the 13% differential was enacted—to 1987, the Plans lost nearly 200,000 small group subscribers. For the five-year period from 1987 to 1991, Empire alone lost more than 650,000 small group subscribers. (JA-164-67.) "[T]he better risks mov[ed] to commercial insurers who offer lower premiums." (JA-168.)

making one type of coverage more attractive than another would have an impermissible discriminatory impact upon ERISA plans. Since countless state laws impact cost and thus may influence choice, states would be required to leave cost and availability of healthcare primarily to the free market. Apparently, the sole freedom Travelers would allow the legislature is to set a uniform rate for all payors, including Article 43 corporations, commercial insurers, HMOs, self-insured funds, Medicaid, uninsured individuals, etc., provided that it also repeals the multitude of other laws that may impact the costs or choice of providing particular benefits or structuring ERISA plans in a particular fashion.[8]

Here, the challenged differentials do not impermissibly interfere with plan choices and do not require ERISA plans to be structured or administered in a particular way. Nor do they mandate the provision of particular benefits. As such, any potential for indirect economic impact on ERISA plans does not warrant their preemption.

B. Respondents Mischaracterize the Operation and Effect of the Challenged Statutes

Travelers mischaracterizes the 13% differential by stating that it "refers expressly to self-insured ERISA plans." (Travelers Br. at 27.) Although the statute lists self-insured funds

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[8] The Court should also reject respondents' suggestion that it carve out a broad preemption rule for generally applicable state laws in the healthcare arena because this is the realm where ERISA plans typically operate. (Travelers Br. at 17-18; HMOs Br. at 32; Brief of the National Carriers' Conference Committee as *Amicus Curiae* in Support of Respondents ("National Carriers' Br.") at 15; NYSA-ILA Br. at 7-8.) There is no support in either ERISA's legislative history or this Court's decisions for a finding that ERISA plans should be granted special privileges excluding them from complying with any generally applicable state law in areas where they provide benefits. To the contrary, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), this Court held that ERISA preempted a law that provided favorable treatment to ERISA plans.

as one category of payor, not all self-insured funds are governed by ERISA. And, at the very outset of its analysis, the Second Circuit specifically held that "the challenged statutes do not refer to ERISA plans." (JA-52); *accord United Wire*, 995 F.2d at 1192 n.6 (holding New Jersey's statute is not preempted "simply because it expressly refers to 'self-funded union' plans as one example of a 'third party payor' "). In fact, Travelers concedes that the statute makes no mention of "ERISA plans" or "employee welfare benefit plans." (Travelers Br. at 27.)

The Public Health Law's passing reference to payments made on behalf of "patients . . . enrolled in a self-insured fund," (A-102), is hardly equivalent to the reference to ERISA plans found in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), or *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580 (1992). In *FMC*, the Pennsylvania antisubrogation statute was preempted because its reference to " '[a]ny program, group contract or other arrangement for payment of benefits' " was part and parcel of a statute requiring ERISA plans to forego subrogation rights. 498 U.S. at 59 (quoting 75 Pa. Cons. Stat. § 1719 (1987)). Similarly, the workers' compensation statute in *Greater Washington Board of Trade* required employers to provide eligible employees with health insurance coverage "measured by reference 'to the existing health insurance coverage' provided by the employer . . . ." 113 S. Ct. at 583 (quoting D.C. Code Ann. § 36-307(a-1)(1) (Supp. 1992)). By contrast, Section 2807-c(1)(b)'s list of payors does not refer to an ERISA plan merely because the term "self-insured fund" is used regardless of its context, and here the context makes clear that the reference is to payors for hospital services.

Apparently recognizing the difference between laws mandating conduct and laws having the potential for only an indirect economic impact on plans, respondents erroneously attempt to transform the differentials into a mandate. (Travelers Br. at 18-19; HMOs Br. at 28-29.) However, contrary to

respondents' assertions, the mandated benefit law at issue in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), was preempted because it was a mandate imposed on ERISA plans—no such mandate on ERISA plans or any other purchasers of hospital services appears here.[9]

Finally, the HMOs' attempt to make themselves synonymous with ERISA plans simply does not do justice to the seriousness of the matters before this Court. Relying upon ERISA's definition of employee welfare benefit plans, the HMOs would conclude that "a law that regulates the means by which an ERISA plan delivers its benefits is self-evidently a law that has a 'connection with' ERISA plans." (HMOs Br. at 20.) However, that ERISA employee welfare benefit plans are defined as plans that provide employee benefits "through insurance or otherwise," 29 U.S.C. § 1002(1), sheds no light whatsoever on the preemption issue. Moreover, if the HMOs are correct, any law regulating insurance companies, self-funded plans or HMOs would "relate to" ERISA plans regardless of how remote or tenuous the relationship to such plan. Similarly unconvincing is the HMOs' argument that because

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[9] The HMOs' reliance upon *Morales v. Trans World Airlines, Inc.*, 112 S. Ct. 2031 (1992), *Wisconsin Department of Industry, Labor and Human Relations v. Gould Inc.*, 475 U.S. 282 (1986), and *Golden State Transit Corp. v. Los Angeles*, 475 U.S. 608 (1986), is similarly unavailing. *Morales* involved the Airline Deregulation Act ("ADA"), which preempts laws "relating to rates, routes or service of any air carrier." 49 U.S.C. § 1305(a)(1) (1988). The Court held that guidelines setting forth the content of air fare advertisements were preempted. First, "every one of the [regulations]. . . [bore] a 'reference to' air fares." *Morales*, 112 S. Ct. at 2039. Second, unlike the challenged differentials, the guidelines had a direct economic effect on air fares. *Gould Inc.* and *Golden State Transit Corp.* similarly addressed statutes mandating or restricting particular conduct.

Interestingly, this Court has found that a state regulation increasing the cost of alcohol from out-of-state sources was not preempted because it "simply raise[d the] price." It did not preclude the military from complying with its obligation to obtain liquor at the most competitive price. *North Dakota v. United States*, 495 U.S. 423, 441 (1990).

they provide healthcare, they are "a surrogate for the ERISA plan." (HMOs Br. at 20.) Were the test providing healthcare, doctors and hospitals would also be "surrogates" for ERISA plans.

C. The Challenged Differentials Do Not Impermissibly Interfere with National Uniformity of Plan Administration

While admitting that hospital costs will vary from hospital to hospital and state to state regardless of whether states regulate rates, Travelers nonetheless contends that states may not alter cost differences so as to "produce *state-created* disuniformity that burdens multi-state plans' attempts to take advantage of the efficiencies of the national market." (Travelers Br. at 23.) Thus, Travelers urges that differences in costs are acceptable so long as those differences are created by market factors alone. Unfortunately, this approach cannot be reconciled with Travelers' position that they are not challenging the DRG system in New York.[10]

In any event, free market conditions will make certain types of coverage more attractive in some states than in others. For example, in some states an employee benefit plan may have a large number of employees in a small area and be able to negotiate favorable hospital rates for its own participants. In other states, the plan may have only a small number of employees and find that it can save the most money by providing coverage through some insurer.

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[10] Although Travelers maintains that it is not challenging New York State's DRG system, *amici* disagree. Recognizing the difficulty of maintaining Travelers' position, *amici* apparently favor a completely free market system. (*See, e.g.*, Brief *Amicus Curiae* for the International Foundation of Employee Benefit Plans in support of Respondents at 12-14; Brief *Amicus Curiae* of the Self-Insurance Institute of America, Inc. in Support of the Respondents at 14.)

D. Congress Did Not Intend to Preempt State Hospital Cost Control and Insurance Regulatory Schemes

Contesting petitioners' position that Congress did not intend to preempt state hospital cost control and insurance regulatory schemes, Travelers relies upon the undisputed fact that Congress intended that preemption be construed broadly. Yet neither Travelers nor *amici* have pointed to anything in ERISA's legislative history specifying an intent to preempt laws such as the challenged differentials. Nor have the HMOs provided any basis for their assertion that Congress determined to leave such matters to the free market.

Respondents also erroneously rely upon the congressional amendment exempting the "Hawaii Prepaid Health Care Act" from ERISA preemption. (*See* Travelers Br. at 30-31; HMOs Br. at 38-39.) But that amendment was enacted specifically in response to a court ruling that Hawaii's *mandatory* employer coverage was preempted. There is no evidence that Congress considered preemption of laws that control hospital costs, regulate insurance and may have a purely indirect economic impact upon choices made by ERISA plans.

Here, affirming the Second Circuit's decision would threaten a wide range of state laws designed to control costs and increase the availability of hospital and medical insurance coverage. (*See* Brief for the States of Minnesota, *et al.* at 16-27 (describing the impact of the Second Circuit's ruling).) Surely, Congress did not intend that ERISA preemption would threaten such drastic ramifications.

II.

NEW YORK'S DIFFERENTIALS ARE SAVED AS INSURANCE REGULATION

In respondents' saving clause argument, the differentials have been somehow transformed from "purposeful interference" with choices of employee benefit plans, solely into regulation of hospital rates. On this score respondents meet themselves coming and going: Respondents simply cannot have it both ways.

And, contrary to respondents' assertion, petitioners do not contend that all laws that "relate to" insurance companies are saved from preemption. Instead, petitioners maintain simply, as this Court's precedents make clear, that the insurance saving clause "save[s] an entire body of law from the sweeping general pre-emption clause." *Metropolitan Life*, 471 U.S. at 746 n.23. In fact, in *Metropolitan Life* this Court refused to construe the saving clause narrowly, finding that it would result in an "unnatural reading of the clause." *Id.*

A. From a Common Sense Perspective the Differentials Regulate Insurance

For decades, New York State's regulation of insurance has been inextricably intertwined with the regulation of hospital rates. Respondents' assertion that the differentials deal only with the payments made by an insurer to the hospital ignores the legislative history, discussions, studies and debates about them that explain how New York seeks to affect the availability and affordability of insurance through the regulation of hospital reimbursement rates. The differentials are not "removed from the contractual relationship" between the policyholder and the insurer—the Record clearly establishes that the differentials are part of the State's plan to promote New Yorkers' access to affordable health insurance.[11] The inno-

[11] Travelers argues that the differentials are not designed to increase access to insurance because they remain in effect even after the

vativeness of the differentials, or as respondents describe them, their "uniqueness" or "unusualness," (*see* Travelers Br. at 3, 35), provides no basis for concluding that such laws do not regulate insurance.[12]

B. Since the Differentials Regulate Insurance as a Matter of Common Sense, Application of the McCarran-Ferguson Act Factors Is Not Warranted

Again, as this Court's precedents establish, this Court "*made use* of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act" and "[was] *guided*" by such case law. *Pilot Life*, 481 U.S. at 48 (emphasis added). However, the three prong test applied in *Metropolitan Life* and *Pilot Life* was originally developed to determine whether a law was exempt from the antitrust laws because it regulated the "business of insurance." *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The key differences in language between ERISA and the McCarran-Ferguson Act indicate that McCarran's three prong test need not be met in the ERISA context.

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enactment of New York's landmark reform requiring insurers in individual and small group markets to open enroll and community rate. This argument obfuscates the impact of the reform law. (*See* Travelers Br. at 7 n.5.) As previously stated, (Brief for Petitioners New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield ("Br.") at 9-10 n.8, 38 n.27), under the reform law, no commercial insurer is required to be in the individual or small group health insurance market. Accordingly, most commercial insurers choose not to cover individuals, thus leaving persons with the highest claims cost in the State to be insured by the Plans. (JA-201, 294.) For this reason, the legislature decided to maintain the present differential until the end of 1995.

[12] Contrary to Travelers' assertion, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987), does not support the position that the differentials do not regulate insurance as a matter of common sense. Unlike this action, *Pilot Life* involved a law having its roots in general tort and contract law. Here, the history of the differentials repeatedly underscores their insurance function. (JA-160-68, 216-38.)

As discussed fully in the Plans' principal brief, (Br. at 34-36), *United States Department of the Treasury v. Fabe* broadly applied the three-prong test recognizing that the McCarran-Ferguson Act factors could be applied less rigidly when determining whether a law enacted within the states' traditional police power is exempt from preemption as the business of insurance than when applying the antitrust exemption in 15 U.S.C. § 1012(b). 113 S. Ct. 2202, 2209-10 (1993). Therefore, in the context of the ERISA saving clause, the McCarran-Ferguson factors, which merely provide "guidance" to the Court and are not "necessarily determinative," need not be satisfied. *See Pilot Life*, 481 U.S. at 48; *Union Labor Life Ins. Co.*, 458 U.S. at 129.

C. In Any Event the Differentials Meet the Requirements of the McCarran-Ferguson Act

1. The Differentials Spread Risk

Respondents erroneously attempt to liken the differentials to the private price agreements in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Here, the Second Circuit correctly held that the differentials spread risk, unlike the private pharmacy agreements in *Royal Drug* which merely allowed the health insurer to reduce its costs for obligations already assumed. (JA-59.) Distinguishing *Royal Drug*, the Second Circuit acknowledged that the differentials' purpose was to encourage healthier persons to participate in the Plans' community pools, and that therefore, the differentials go much further than merely setting a price. (JA-59.)[13]

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[13] Respondents' attempt to distinguish the risk spreading in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), also fails. The differentials, like the mandated benefit law in *Metropolitan Life*, were designed as an insurance law so that "good risk individuals . . . become part of the risk pool" in order to "correct the insurance market." *Id.* at 731.

2. The Differentials Are Integral to the Insurer-Insured Relationship

Travelers concedes that " '[c]ommunity rating and open enrollment'. . . 'play an integral role in the policy relationship between insurer and insured,' " yet argues that the differentials are not integral to that relationship because they "simply increase the prices that hospitals charge patients with certain health coverage, and do not *regulate* community rating and open enrollment . . . ." (Travelers Br. at 40.) However, this ignores the key role that the differentials play in fostering the Plans' ability to provide health insurance to all who seek it, especially those who can not otherwise obtain it. *See supra* note 11. One need only consider the plight of a person who was dropped from coverage by a commercial insurer and was able to obtain coverage from the Plans to determine if such access, stimulated by the differential, is the regulation of insurance. Surely, the differentials are integral to the State's policy of providing broad access to coverage and, therefore, are integral to the relationship between the insured and the insurer.[14]

3. HMOs Are Subject to ERISA's Saving Clause

Under the Second Circuit's ruling, no insurance statute can be saved from ERISA preemption if it applies to HMOs because such a statute would not be considered limited to entities in the insurance industry. However, to the extent HMOs perform insurance functions they are "persons" subject

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[14] Contrary to Travelers' position, *Royal Drug* does not demonstrate that the differentials are not integral to the policy relationship between the insurer and the insured. Unlike the pharmacy agreements in *Royal Drug* (where the contractual arrangement between the pharmacy and the insurer had no connection with the relationship with the insured), the state created the differentials to stimulate practices resulting in insurers providing broad access to coverage for insureds. (Br. at 10-13.)

to laws which "regulate insurance."[15] 29 U.S.C. § 1144(b)(2)(A) (1988).

The HMOs expend great effort informing this Court about how different they are from the Plans and commercial insurers. This is all immaterial to the issue before this Court. Regarding payments for hospital services, HMOs are no different than insurers. HMOs do not provide hospital care: They pay for it just like the Plans and commercial insurers by accepting the risks in providing hospital care and indemnifying their subscribers for such costs in exchange for a premium payment. *See* Br. at 42-43; *see also Ocean State Physicians Health Plan v. Blue Cross & Blue Shield*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); Philip S. Neal & Suzanne M. Papiewski, *Taxation of HMOs Now and Under Health Care Reform—Separating Fact from Fiction*, Exempt Organization Tax Review, Vol. 9, No. 3 (March 1994). And as noted in the Plans' brief, (Br. at 44-46), many courts have correctly found that HMOs perform an insurance function when they accept premium payments in exchange for healthcare services because the HMOs remain at risk.[16] Significantly, from a national perspective, *amici* The National Governors' Association and The National Association of Insurance Commissioners agree that HMOs engage in

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[15] Contrary to the HMOs' contention, HMOs are not subject to insurance regulation only as determined by the Department of Health. (HMOs Br. at 46.) Rather, HMOs are subject to specific insurance regulations in accordance with the provisions of N.Y. Ins. Law § 1109(a) as well the Public Health Law. (*See* Br. at 42-44.)

[16] Respondents' citation to the more than 50 year-old case of *Jordan v. Group Health*, 107 F.2d 239 (D.C. Cir. 1939), does not change this result. In *Jordan*, no risk was transferred to the HMO: It merely had to use its best efforts to arrange for care. The only other circuit court case cited by respondents, *O'Reilly v. Ceuleers*, 912 F.2d 1383 (11th Cir. 1990), is equally inapplicable. *O'Reilly* concerned an HMO in its role as the fiduciary of its own employee benefit plan and did not address whether a law applicable to the HMO was saved as insurance regulation.

the primary insurance function ("assumption of third party's risk in return for a fixed payment") and that HMOs are not clearly distinct from insurers because many insurers "provide coverage through managed care arrangements which deliver services through provider networks, as do HMOs." (Brief for National Governors' Association *et al.* as *Amici Curiae* in Support of Petitioners at 12-13 n.7.) The bottom line is that HMOs and insurers perform the same functions for individuals paying premiums—they accept the risk of providing healthcare services.

The HMOs' reliance on the provisions of the Health Maintenance Organizations Act of 1973 is likewise misplaced. Through the HMO Act, Congress sought to provide "strong federal commitment to the growth and development of [HMOs]" and, accordingly, restricted specific types of state laws which it deemed might stifle that growth. S. Rep. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3057. Thus, 42 U.S.C. § 300e-10 exempts HMOs from state insurance laws "respecting initial capitalization and establishment of financial reserves against insolvency". However, although it could have done so, Congress did not preempt the application of all insurance laws as to HMOs. In fact, since the HMO Act restricts *only* insurance laws relating to capital and insolvency, Congress was obviously aware that insurance statutes were applicable to HMOs.[17]

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[17] Finally, ERISA's definition of employee benefit plan, 29 U.S.C. § 1002(1), which allows plans to provide benefits "through insurance or otherwise," provides no support for the HMOs' claim that the saving clause does not include laws regulating HMOs within its reach. The "or otherwise" language refers to self-insured plans, but even if it referred to HMOs, this has no bearing upon whether laws that apply to HMOs and insurers can be saved as insurance regulation.

D. The Deemer Clause Is Not Applicable

Nor does ERISA's deemer clause operate to preempt the challenged differentials as to self-insured plans.[18] The "deemer" clause provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies.

29 U.S.C. § 1144(b)(2)(B) (1988).

New York's hospital reimbursement and insurance regulatory scheme regulates the hospital rates of all categories of payors. *See* N.Y. Pub. Health Law § 2807-c(1) (McKinney 1993). Indeed, to be effective as a coherent, integrated system, it must encompass all payors, "not just insurance companies." (JA-276.) Yet from this it does not follow that the statute "purports" to regulate self-insured funds as "insurance companies" as required by the deemer clause. Rather than "deeming" the self-insured funds to be insurers for regulatory

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[18] The Second Circuit neither addressed the applicability of the deemer clause nor specifically discussed preemption of the differentials as to self-insured plans. However, the Plans and Empire acknowledge that respondents and *amici* correctly state that the district court's ruling encompassed self-funded plans. In resolving a controversy involving the scope of the district court's stay pending appeal, Judge Freeh ruled that while the appeal was pending, "the named parties to this action, including Travelers, in its capacity as claims fiduciary of the Railroad Plans [a self-funded plan], are directed to pay the 13% differential with respect to all hospital claims . . . ." (*See* Appendix to National Carriers' Br. at 30a.) Thus, in fashioning his stay order, Judge Freeh took pains to treat self-insured plans exactly as he did commercial insurers. As the Record makes clear, the issue of the applicability of the deemer clause is properly before this Court.

purposes, the challenged statute treats self-insured funds as payors of hospital charges. As such, the deemer clause does not come into play.

The statute at issue here is also distinguishable from that at issue in *FMC Corp. v Holliday*, 498 U.S. 52 (1990), where this Court held that a Pennsylvania anti-subrogation law was preempted as it applied to self-insured plans even though it was saved as to insured plans. Pennsylvania's anti-subrogation law directly prohibited the self-insured plan from recovering the benefits it had paid to plan participants out of their tort recovery. In other words, the statute prohibited the plan from acting in accordance with its explicit provisions. In that respect, the anti-subrogation law in *FMC* is identical to the mandated benefit law upheld with respect to insurers but not self-insured funds in *Metropolitan Life*.

By contrast, the challenged statutes control the rates of payors for hospital services; they neither require self-funded plans to do anything nor prohibit them from doing anything. In fact, the statutes actually offer an *option* to self-insured plans: They may pay covered hospital costs by either remitting the DRG rate plus the 13% differential paid by essentially every other payor category in New York directly to the hospitals, they may purchase services through the Plans or they may opt out of the DRG system entirely by remitting the hospital's charges to the employee or patient. *See* N.Y. Pub Health Law §§ 2807-*c*(1)(a)-(c) (McKinney 1993). This choice allows self-insured plans to benefit from participation in New York's hospital cost control law, but does not require them to pay the 13% differential. Therefore, unlike *FMC*, whether or not a self-insured plan pays the 13% differential is wholly a matter of choice. Because the differential statute at bar does not impose any regulatory mandates upon self-funded plans but rather treats them as payors for hospital services, the deemer clause does not operate to preempt any portion of the laws at issue.

CONCLUSION

For all of the foregoing reasons, and for all the reasons stated in the Brief for Petitioners New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield, the decision of the Second Circuit Court of Appeals that ERISA preempts New York's statutorily prescribed differentials should be reversed.

Dated: New York, New York
December 28, 1994

Respectfully submitted,

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Nos. 93-1408, 93-1414, and 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
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THE TRAVELERS INSURANCE COMPANY, *et al.*,
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HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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REPLY BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

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On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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REPLY BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

Our opening brief demonstrated that states, in regulating the provision of health care, have commonly recognized that not all payers' rates need be the same,

resulting in a shifting of hospital costs among different categories of payers. The State of New York has provided, for example, that the rates for in-hospital care must reflect the costs of providing care to patients unable to pay. The State has likewise provided that the rates charged to Medicaid patients should be lower than the rates charged to patients covered by commercial insurance or by self-insured funds. Not only are such regulations not considered to be at odds with federal law, but Congress, both before and after passage of the Employee Retirement Income Security Act of 1974 ("ERISA"), has acknowledged and approved of those arrangements. Indeed, Congress has specifically reviewed and approved the NYPHRM system at issue in this case. HANYS Br. 29-33.[1] Respondents have not challenged these propositions.

If these regulations of hospital costs are valid under ERISA—as respondents appear to concede that they are —it is hard to understand why the setting of lower rates for Blue Cross patients is, alone, invalid. The reason offered by respondents is that the different treatment of Blue Cross patients affects the "choices" made by ERISA plans because they might elect to subscribe to Blue Cross and thus benefit from the lower rates. But, as we have previously noted, it seems unlikely that Congress, by the general preemption provision in ERISA, meant to foreclose to ERISA plans an option enjoyed by all other purchasers of health care services in New York. HANYS Br. 34-35.

Moreover, the argument advanced by respondents is, ultimately, hollow. The State for many years has subjected Blue Cross to obligations not imposed on other payers (like commercial insurers and health maintenance organizations "HMOs")—obligations that, by increasing

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[1] "HANYS Br." refers to the Brief for Petitioner Hospital Association of New York State (HANYS). Unless otherwise indicated, "Respondents' Brief" or "Resp. Br." refers to the Brief for Respondents The Travelers Insurance Company, *et al.*

the costs of Blue Cross, or decreasing the costs of its competitors, would presumably influence consumers *not* to elect Blue Cross coverage. Yet respondents have never challenged such *adverse* treatment of Blue Cross, and proceed here as if such different treatment did not exist. As commercial insurers and health maintenance organizations, respondents seek to enjoy all of the benefits of different state regulatory approaches to different insurers, and none of the burdens. Their complaint thus reduces to a result-oriented theory that state efforts which take account of various burdens imposed on Blue Cross are preempted, even though imposition of the burdens in the first place was not. Nothing in ERISA provides support for that awkward proposition.[2]

POINT I

THE STATE IS ENTITLED TO TREAT DIFFERENT CATEGORIES OF PAYERS DIFFERENTLY.

The provision establishing lower in-hospital rates for Blue Cross patients is part of a comprehensive law regulating the provision of health care in New York. Just as New York law sets rates for some patients that reflect the need to facilitate access to hospital care for other patients (*e.g.*, charity and Medicaid patients), the law also provides that patients covered by commercial insurers and self-insured funds, among others, should pay at higher rates than patients of Blue Cross. There is nothing nefarious about this differential; it simply takes ac-

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[2] This Reply Brief on behalf of the Hospital Association of New York State will address only the "relates to" issue. HANYS relies on its discussion of the insurance savings clause in its initial brief. HANYS also relies upon and adopts the arguments on the savings clause contained in the co-petitioners' reply briefs. On the issue of the deemer clause, HANYS agrees with the position of the Petitioners Mario M. Cuomo, *et al.*, that the district court and the Second Circuit did not rule on that issue and, should the issue of the deemer clause need to be resolved, the case should be remanded so that it can be fully briefed.

count of the unique disadvantages under which Blue Cross plans have long operated, and the role Blue Cross has played in meeting the State's public policy objectives.

Respondents' contention that the 13% differential is nevertheless preempted, because it has a sufficient "connection with" ERISA plans, is now limited to the purpose and effect of the differential being to manipulate plan decisions. Resp. Br. 16. Respondents have completely abandoned the economic impact test relied upon by the Second Circuit Court of Appeals, (J.A. 52-55), and now seek a narrow opinion solely on the alternative "purposeful interference" basis for the Second Circuit's holding. Resp. Br. 26. Like the economic impact test, this "purpose" argument is not supportable.

A. The Playing Field

In attacking the New York law, respondents would have this Court start in the middle and assume that all providers of health care coverage are alike and must be treated alike. But this view bears little connection to real life. Commercial insurers, Blue Cross and HMOs operate in entirely different regulatory environments. As respondent HMO Conference points out, there is virtually no similarity between regulation of indemnity insurers and HMOs. The HMO Conference touts its lower premiums, but fails to cite to one of the main reasons; HMOs enjoy the *unique* benefit of being entitled to negotiate their own in-patient rates. N.Y. PUB. HEALTH LAW § 2807-c(2)(b)(i). *See* HANYS Br. nn.6 & 20. In that regard, therefore, it is the choice of Blue Cross over HMOs that is burdened with financial consequences.

Similarly, as between Blue Cross and commercial insurers, Blue Cross is uniquely subject to an extensive, complex regulatory scheme that generates costs that are

passed on in premiums. *See* HANYS Br. n.21.[3] Commercial insurers enjoy another benefit not enjoyed by Blue Cross plans or HMOs, a 2% discount for prompt payment to hospitals. N.Y. PUB. HEALTH LAW § 2807-c (11)(e). *See* HANYS Br. nn. 8 & 20. Each of these different regulatory treatments results in the choice of Blue Cross plans being burdened by financial consequences not experienced with the choice of commercial insurers or HMOs, allowing them to develop premium structures different than Blue Cross could. Commercial insurers, therefore, have enjoyed lower premiums (J.A. 168, ¶ 19), a fact that respondents have not disputed. This is the playing field, together with the costly burdens of open enrollment and community rating, that was being "leveled" by the 13% differential.[4]

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[3] These unique and costly obligations include approval of premiums by the Superintendent of Insurance after public hearing; regulatory controls on administrative expenses, reserves and surpluses; and limitations on other lines of business. *See generally* N.Y. INS. LAW, art. 43; J.A. 160, ¶ 4; J.A. 197, ¶¶ 20-21; J.A. 215-216, ¶ 6.

[4] It is interesting that respondents, who rest their entire "connection with" argument on the purpose and effect of the differential, have themselves disputed the very proposition upon which they now rely, that the 13% differential was intended to "level the playing field" (J.A. 273, ¶ 4):

> [T]he history of the differential is not as the State defendants and Intervenors would have it. They seek to portray the differential as a device designed by the Legislature to level the playing field between Blue Cross and the commercial insurance industry. The facts, however, are somewhat different.

Respondents' position in the District Court was actually the same as HANYS', that the differential, when originally established by statute, was intended to reduce the difference in rates paid by all charge payers, including commercial insurers, and Blue Cross plans. J.A. 243-245, 275-276. In fact, the Record bears only one reference to a purpose of the 13% differential being to level the playing field (J.A. 165-166, ¶ 15).

Moreover, as to respondents' present claim about the 13% differential being targeted at commercial insurers and ERISA plans,

The regulatory structure to which Blue Cross plans are singularly subjected imposes "financial penalties," under respondents' reasoning (Resp. Br. 16), for choosing to insure through Blue Cross. Yet none of these "penalties" is being challenged by respondents, even though they have the exact same effect as the differential; they affect costs and therefore become a consideration in a plan's decisions regarding coverage.[5] Unless all Blue Cross plans, commercial insurers, HMOs and self-insured funds are to be regulated identically, a proposition none of respondents advance, incentives and disincentives will remain in the system. The fact that ERISA plans weigh these considerations can hardly be the basis for preemption. And the hope that the differential would serve to reduce the competitive disadvantages experienced by Blue Cross plans does not equate to a purpose of manipulating the selection by plans of coverage arrangements in order to force ERISA plans not to self-insure or to move from com-

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respondents previously argued that the codification of the differential "was targeted at all payors, including uninsured individuals, not just insurance companies." J.A. 276, ¶ 14.

[5] Under respondents' analyses, there can be no law more subject to preemption than the right singularly granted to HMOs to negotiate their own payment rates to hospitals. The differential pales in comparison to the economic advantage gained by negotiation of one's own rates. This is aptly demonstrated by the HMO Conference's Brief which emphasizes the lower costs to consumers who choose HMO coverage over Blue Cross or commercial insurers. Understandably, the HMOs do not challenge this "interference" in plan decisions, but there is no legal justification for failing to do so if one accepts respondents' arguments. While one might normally wonder why this "preference" for HMOs is not challenged by commercial insurers, the answer is obvious; commercial insurers are rapidly setting up their own HMOs to take advantage of this very disparity in treatment. *See* J.A. 128, ¶ 15; J.A. 125, ¶ 7; J.A. 130, ¶ 5. Commercial insurers, therefore, are not "the disfavored benefit payors" and Blue Cross plans the favored payors. Resp. Br. 16-17. Commercial insurers are "disfavored" in one facet of state regulation; Blue Cross plans are the disfavored insurers in so many other ways.

mercial insurers. By supporting the continued viability of Blue Cross plans, the State has not restricted, it has expanded options for all consumers, including ERISA plans.

B. Influence v. Mandate

Respondents' suggestion that there is no legal difference between the State's merely affecting costs which might influence a plan's decision and actually mandating that decision is incorrect. Resp. Br. 24. If it were correct, and merely influencing choice by affecting cost would suffice for preemption, then the "parade of horribles" (Resp. Br. 25) is a reality. A 1% surcharge would have the same legal effect as the 1000% surcharge posited by respondents. This Court, however, has never held that the mere fact that the impact of state law may influence a plan choice triggers preemption. Resp. Br. 18. This Court has held that where the state law removes plan choice, it is preempted. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

There is no limit to the number of state laws that will generate costs that may influence plan decisions, and, therefore, a law's having the effect of influencing a plan decision simply cannot logically be the test for preemption. It is when the influence becomes not just a factor, but effectively mandates that choice that preemption may be triggered. For example, it would be implausible to think that Massachusetts could not use various incentives to encourage insurance policies to cover mental health benefits (Resp. Br. 24)—such as by putting ceilings on the rates charged for such services—even though it is not free to mandate them. Indeed, those types of incentives are prevalent throughout the DRG system, a fact that respondents accept.[6] Although it may be that, at some

[6] By establishing prices, or rates, for different in-patient procedures, the State by definition, using respondents' phraseology,

point, laws regulating costs may so tilt the balance that they leave plans and other consumers little practical choice, that is hardly the case here. A 13% differential applied to one of many services covered by health insurance simply does not rise to that level.

It is not surprising, therefore, that the Record in this case contains no evidence at all that any plan's choice of coverage was mandated by the 13% differential. In fact, there is not a scintilla of evidence in the Record that any benefit levels have been reduced because of the 13% differential, or that a decision was made not to offer a benefit because of the 13% differential. The Record is not only devoid of support for respondents' overstatements about controlling and mandating plan coverage decisions (*see, e.g.*, Resp. Br. 25), but the only evidence in the Record is directly to the contrary, that ERISA plans change from Blue Cross *to the Travelers* for "superior performance" (J.A. 268, 270-71) and because of lower premiums. J.A. 168, ¶ 19.[7] By virtue of the interplay of subsections (a)-(c) of N.Y. PUB. HEALTH LAW § 2807-c(1), the State has afforded all consumers, including ERISA plans, more choice, and as discussed in our initial brief (HANYS Br. 34-35), affording plans the

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steps in and artificially alters the cost of hospital services that would otherwise exist in the free market. State-regulated rates will always reflect some state biases, such as for out-patient over in-patient procedures, and for reduced lengths of stay.

[7] One hearsay statement is made on behalf of respondents that certain plans may have changed their form of coverage in response to the 11% surcharge. J.A. 134, ¶ 14. No such statement is made anywhere about the 13% differential, in any of the 17 affidavits submitted on respondents' behalves (J.A. 115-145, 267-289, 298-300, 321-325, 336-340). This is apparently one reason why respondents attempt to blur the differences between these very different statutory enactments. These differences were not only recognized by the Second Circuit Court of Appeals (A-41), but even by respondents, The Travelers *et al.*, (J.A. 287, ¶ 3, Resp. Br. 3) and the HMO Conference (HMO Br. 7, 14, 16, 25).

same choices as all other consumers would be an illogical ground upon which to find preemption.

Lastly, Congress could not have intended the line for ERISA preemption to be drawn at the point where state laws may influence plan decisions, since the bounds of preemption would be no less broad than if economic impact alone were the test.[8] The contention advanced by respondents is that a law whose economic impact upon plans will differ based upon the choice of coverage necessarily becomes a factor in the plan's coverage decision. This is the influence, they say, that triggers preemption. But as explained in the briefs of petitioners and their amici, such expansive preemption would invalidate laws that could not have been within the intended scope of preemption.

For example, when New York State in 1988 completely revamped its hospital quality assurance regulations, contained in Title 10 New York Code of Rules and Regulations, the cost alone of the graduate medical education component of the regulations for just the first year was $122 million. J.A. 186, ¶ 32. These costs were then added into hospital rates and distributed among all payers, except Medicare. The impact of the new Part 405 regulations is no less than that of the differential and may not only influence plan decisions on the level of benefits to be offered, it may also influence coverage decisions. Self-insured plans, rather than paying the full increase themselves, may elect to insure through commercial insurers

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[8] While respondents The Travelers *et al.*, have abandoned the economic impact argument, respondents HMO Conference *et al.*, continue to argue the economic impact test advanced by the Second Circuit (*see, e.g.*, HMO Br. 29), as do their Amici. *See, e.g.*, GHAA Br. 5. Amici Trustees of and the Pension, Hospitalization Benefit Plan, *et al.*, not only argue for the economic impact test, but ask this Court to assure that the state's funding mechanism for bad debt and charity care also be held to be preempted. Amicus Federation of American Health Systems is arguing for a free market system. FAHS Br. 2, 3.

because of a lesser impact of the rate increase on premiums. If a regulation is preempted because it will cause plans to expend greater plan assets or reduce benefit levels, or consider changing coverage, then the entire Part 405 quality assurance regulations are preempted. Congress could not have intended the field of employee benefits to extend so far.

C. Congressional Intent

Contrary to respondents' contention (Resp. Br. 12, n.6), congressional intent is still the ultimate touchstone of the preemption analysis, whether the preemption be express or implied. *Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992). Even with an express preemption provision, congressional intent must be distilled from more than the statute's language where such language is not narrow and precise (*Id.*) Apart from the presumption against preemption of the state's police powers (*Cipollone, supra* at 2618), ERISA's own legislative history offers no indication that Congress intended to broaden the field of employee benefits to cover generally applicable laws (i.e., hospital rate-setting activity) that were not commonly thought of as part of the employee benefit field, and whose only impact upon plans is indirect and economic.[9]

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[9] Addressing Representative Dent's statement that ERISA's preemption provision was patterned after the preemption approach in the Health Maintenance Organization Act of 1973, respondents recite a subsequent observation of Representative Dent that ERISA preempts essentially any act of the state which would affect any employee benefit plan. *See* Resp. Br. 30, n.15. The thrust of that statement, however, was not to show that any law that *affects* a plan is preempted, which has never been the test, but that ERISA preemption can operate against any form of state act that can be viewed as under the color of state law. In fact, in the Senate floor debates, Senator Taft cited Representative Dent's remarks for that "color of state law" point when he asked Senator Javits whether state bar association rules could be subject to ERISA preemption. *3 Legislative History of the Employee Retirement Income Security Act of 1974*, 4789, HANYS Br. 22.

Rather, Congress's very substantial and specific activity in the Medicare and Medicaid fields advocating for and approving of states' rate-setting laws that encompass all payers, and in particular systems in which all payers do not pay the same rates, reflect that the field to be pre-empted did not include all-payor rate-setting systems like New York's. HANYS Br. 29-33. Petitioners are not seeking to "carve-out" a general exception for health care; the point is that this law is simply not preempted because it is not "connected with" ERISA plans as was envisioned by Congress when it made the federal government the exclusive authority over the field of employee benefits.[10] Congressional intent in health care would be thwarted if ERISA preempted rate-setting laws that treat ERISA plans neutrally, and whose only impact is indirect and economic, and which does not remove plans' freedom of choice. Respondents have studiously avoided addressing this point.

Nor is the goal of national uniformity advanced, since unlike the field of employee benefits, health care regulation, rate-setting and cost control, as well as insurance regulation, are and have always been matters purely of local concern and interest. Hospital regulation, hospital costs, and insurance regulation, including different treatment of Blue Cross plans, commercial insurers and HMOs, are inherently local, police power exercises, and the manner in which those police powers are exercised differs within every state. (*See, e.g.*, J.A. 189-192, J.A. 256-257; *see also Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 240-41, n.6 (1979)). Respondents' distinction between free market and "state-created" disuniformities (Resp. Br. 23) is therefore unavailing;

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[10] Respondents reference to *Agsalud v. Standard Oil Co.*, 454 U.S. 801 (1981) (Resp. Br. 31) is irrelevant. *Agsalud* involved a statute that was clearly preempted because it directly and expressly regulated employers and the types of benefits they provide. Congress's subsequent exemption of the Hawaii statute is not informative as to the reach of ERISA preemption.

there is no free market in hospital care or insurance. As stated above, respondents do not contend that regulation of all insurance entities has to be uniform within a state or among states. If it is not uniform, there will always be advantages and disadvantages, incentives and disincentives built into the systems. National uniformity would not be furthered by elimination of the 13% differential.[11]

POINT II

THERE IS NO REFERENCE TO ERISA PLANS.

Respondents also submit that ERISA preempts the 13% differential because the provisions comprising the differential "refer to self-insured plans," (Resp. Br. 27-28), instead of using the term "all third-party payers." *See* N.Y. PUB. HEALTH LAW § 2807-c(1)(b). This argument was summarily dismissed by both courts below (Pet. App. A-22, A-71), and is unavailing here.

Public Health Law sections 2807-c(1)(a), (b) and (c) set rates for everyone by listing all categories of patients covered by the statute, including "self-insured funds".[12] There is simply no legal significance to listing

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[11] National uniformity fails as a basis for preemption for the additional reason that insured plans pay premiums, not hospital rates. Eliminating the differential will not eliminate differences in premiums, which are based upon numerous factors and costs individual to the insurer; it would just rearrange them. Since Blue Cross premiums are generally higher than commercial insurance premiums, elimination of the differential will, if anything, increase the disparity in premiums. Congress certainly could not have intended ERISA to mandate uniformity of premiums of all payers in every state.

The point is the same for self-insured plans, which do pay hospital rates. Unless Congress intended to require that hospital rates and Blue Cross premiums be identical, which is impossible, there will always be these differences and incentives, with or without the differential.

[12] The terms "self-insured fund" and "ERISA plan" simply are not synonymous. First, not all ERISA plans are self-insured funds.

the payers covered by section 2807-c(1)(b), as opposed merely to referring to "all other payers." It would be virtually impossible to regulate health care, particularly in the context of an all-payor reimbursement system, without the use of some term or phrase that may cover ERISA plans. Finding "reference" under such circumstances is inconsistent with the common sense approach of determining whether a state law relates to an ERISA plan (*Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987)), since such an interpretation of that term will, almost inevitably, pose a threat of preemption to every state all-payor rate system, which respondents concede Congress did not intend. In the context of state regulation of health care costs and reimbursement, common sense requires that a statute has to do more than *encompass* ERISA plans for it to be held to *refer* to ERISA plans.[18] Respondents' position is also inconsistent

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A large percentage of ERISA plans, as respondents emphasize, purchase commercial insurance, Blue Cross or HMO coverage. The "reference to" argument would not even apply to those plans, since they are not encompassed within self-insured funds. Similarly, not all self-insured funds are ERISA plans. A governmental plan, for instance, self-insures but is not governed by ERISA. See ERISA § 4(b)(1), 29 U.S.C. § 1003(b)(1). The term "self-insured funds" also encompasses a range of entities that have nothing to do with any type of employee benefit plan, such as trade association funds. The point is that the statute does not make a reference to ERISA plans themselves; it just makes a reference to the categories of payers which may be used by a plan.

[18] Indeed, as the Third Circuit observed in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179, 1192, n.6 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), ERISA does not even preempt a state law that refers directly to the term "ERISA plan" where that reference can be excised without altering the legal effect of a statute in any way, such as a statute that prohibits race discrimination "including by an ERISA plan." Similarly, under respondents' reasoning, if the generally-applicable garnishment statute that was upheld in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), had listed every type of fund (including ERISA welfare funds) that could

with the fact that they accept the validity of the State's "even-handed" DRG methodology (*See* Resp. Br. 27), which also necessarily encompasses self-insured funds.[14]

CONCLUSION

The judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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have been subject to the state's garnishment procedure, it would have been preempted, even though its meaning would have been identical to the actual statute at issue in that case.

[14] Respondents' reliance on *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580 (1992) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) is therefore misplaced. In those cases, the laws at issue specifically addressed employee benefit plans, requiring them to structure their benefits in a certain manner. Because they were targeted at, and indeed, "premised on the existence of," employee benefit plans, (*see Ingersoll-Rand v. McClendon*, 498 U.S. 133, 140 (1990)), they "referred to" such plans. Those laws were thus vastly different from the generally-applicable law at issue here, which includes the term "self-insured funds" merely as a means of rounding out a complete list of payers, and not as a means of targeting either those funds, or ERISA plans, which may or may not be self-insured funds.

(26) (27) (27)

Nos. 93-1408, 93-1414, 93-1415

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IN THE
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OCTOBER TERM, 1994

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v.
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Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
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HOSPITAL ASSOCIATION OF NEW YORK STATE,
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v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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REPLY BRIEF FOR PETITIONERS MARIO M. CUOMO, *ET AL.*

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REPLY BRIEF FOR PETITIONERS MARIO M. CUOMO, *ET AL.*

This brief is submitted by petitioners Mario M. Cuomo, *et al.* ("New York") in reply to the briefs of the respondents, The Travelers Insurance Company, *et al.* ("commercials"), the New York State Conference of Health Maintenance Organizations ("HMOs"), and their various

amici. New York's reply brief will address only the issue of whether the State's health care assessments "relate to" ERISA plans within § 514(a) of ERISA, 29 U.S.C. § 1144(a). Having abandoned their argument made before the courts below that the health care assessments are preempted solely because they raise ERISA plan costs, respondents now argue that the assessments are preempted because their indirect economic effect on plan costs purposefully interferes with a fundamental decision of ERISA plans, the choice of health care coverage. (Trav. Br. 16; HMO Br. 19). Even assuming that a state law would be preempted by ERISA on that basis, this argument finds no support in the record below or in the factual findings of the district court.[1]

Moreover, while respondents purport to limit their challenge to what they characterize as "discriminatory" assessments, and imply that uniform regulation does not "relate to" plans,[2] respondents' theory permits no such

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[1] The district court found that the assessments lead indirectly to an increase in plan costs and that this effect, although indeterminate, was substantial. (A. 70-73). The court found that, in response to the cost increase, "plans may reduce the level of benefits or services offered rather than increase costs to participants—a burden on plan administration which ERISA was designed to avoid." (A. 74). The district court did not find that this economic effect influenced or interfered with the decisions of plans concerning the choice of health care coverage. Nor could the district court have made such a finding based upon the only evidence submitted by the commercials and the HMOs showing that increased costs would be passed along to plans in premiums or subscriber fees (A. 71), and the evidence submitted by the State and the intervenors as to the different purposes of each assessment. *See, infra*, p. 6 n.7.

[2] The *amici* argue, however, that uniform hospital rate regulation, for example, New York's bad debt and charity care allowance, which is part of every patient's hospital bill (*see*, N.Y. Pub. Health Law § 2807-c(14)), is preempted because it increases the cost of hospital care and because variations from state to state interfere with uniform plan design. (*See, e.g.*, Brief of National Coordinating Committee of Multiemployer Plans ("NCCMP") at 24-25; Brief of International Foundation of Employee Benefit Plans ("IFEBP") at 12-13). The HMOs expand this "discrimination"

distinction and would compel preemption of virtually all state attempts to regulate health care and control health care costs. State regulation, whether applied uniformly or not, may influence some ERISA plan decisions concerning their structure or administration, including decisions on whether to provide benefits, which benefits to provide, upon what terms to provide benefits, and how to provide benefits.

Under respondents' theory, state laws whose only impact on plans is the indirect economic one of increasing the cost of goods and services purchased by plans are preempted by ERISA. This argument sweeps far too broadly. New York's position is that states may, without facing preemption by ERISA, impose legal obligations upon entities with which ERISA plans do business, *e.g.*, hospitals, day care centers, insurance companies, and HMOs, even if the state regulation may influence plan decisions, so long as it does not dictate or restrict ERISA plans' structure or administration.

ARGUMENT

I. THE HEALTH CARE ASSESSMENTS AFFECT ERISA PLANS ALONG WITH OTHER PARTICIPANTS IN THE HEALTH CARE MARKETPLACE.

While respondents cannot deny that the health care assessments are not directed at, and do not affect solely, ERISA plans, they portray the assessments in that manner. (Trav. Br. 13, 16-19; HMO Br. 20-24).[3] Contrary

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theory, arguing that any regulation imposed upon HMOs, but not upon Blue Cross or commercial insurers, is discriminatory and, therefore, is preempted if it has an adverse economic impact upon HMO rates (HMO Br. 19).

[3] Although they point to the roughly 88% of non-elderly Americans with private health insurance who receive their health care coverage through their employers (JA 35), that does not mean that 88% of the impact of the health care assessments is on ERISA plans. ERISA plans do not pay 88% of hospital bills because not all health care plans are covered by ERISA. A large number of hospital bills are also paid by public programs, such as Medicare and Medicaid. In addition, a large number of elderly persons,

to that portrayal, without regard to their purpose or effect, the health care assessments take in all participants in the health care marketplace, specifically consumers of hospital services or HMOs (in the case of the 9% assessment), not just ERISA plans. This distinction is significant because laws that refer to, apply solely to, or are dependent upon, ERISA plans may be preempted for that reason alone.[4] *District of Columbia v. Greater Washington Board of Trade*, —— U.S. ——, 113 S.Ct. 580 (1992). Thus, New York does not argue, as the commercials claim (Trav. Br. 13), that all laws of general applicability are exempt from ERISA preemption or subject to a different standard.[5]

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excluded from the 88% figure, have Medicare supplemental health care coverage through private insurance. The record shows that, in 1985, one million of them received that coverage through Blue Cross (Anderman Aff., Exh. "B", p. 6). The Hospital Association of New York State ("HANYS") estimates that 25% of hospital bills in New York are paid by ERISA plans (HANYS Br. 24 n.19).

[4] The Second Circuit held that the assessments do not "refer to" plans (JA 52). The commercials again argue that the 13% surcharge refers to ERISA plans, *i.e.*, "self-insured funds," and that this reference is sufficient to preempt the entire statute. (Trav. Br. 27-28). As a factual matter, however, a reference to a self-insured fund is not a reference to an ERISA plan or even to an employee benefit plan since not all self-insured funds are employee benefit plans. For example, professional or trade associations, such as the American Bar Association, may choose to provide health coverage to their members through self-insurance. Such association insurance programs are not ERISA plans because they are not established by "an employer or by an employee organization." 29 U.S.C. § 1002(1). Nor, obviously, are all employee benefit plans self-insured funds. Moreover, the reference to "self-insured funds" in the Public Health Law is in a listing of all the payors subject to the 13% differential. Thus, the statute would have the same legal effect if it read "all other payors except as provided in N.Y. Pub. Health Law § 2807-c(1)(c)."

[5] The HMO's argument (HMO Br. 32) that the 9% assessment is not a law of general applicability because it is directed at health care ignores the fact that ERISA's concern is with employee benefit plans, not with the benefits that plans may offer. The HMOs'

Nor, contrary to the portrayal of respondents and *amici* (HMO Br. 21; IFEBP Br. 13; NCCMP Br. 5, 17), is this a case in which the state law, although generally applicable, burdens ERISA plans disproportionately, either purposefully or by effect. All payors of hospital bills, including Blue Cross, commercial insurers, HMOs, and self-funded groups include a significant number of ERISA plans as customers. To the extent that any of these entities is burdened or benefitted by the health care assessments, the benefits or burdens may be passed onto ERISA plans among others, such as individual payors and non-ERISA plans. Thus, New York's laws do not, by purpose or effect, burden ERISA plans while benefitting other purchasers of hospital services or other customers of HMOs.

II. STATE LAWS THAT IMPOSE LEGAL OBLIGATIONS UPON ENTITIES WITH WHICH ERISA PLANS DO BUSINESS, BUT WHICH HAVE ONLY AN ECONOMIC IMPACT UPON PLANS AND WHICH DO NOT DICTATE OR RESTRICT PLAN CHOICE, DO NOT "RELATE TO" PLANS.

A. A State Law Which Does Not Dictate Or Restrict Plan Choice, But Which Has An Indirect Economic Impact On Plan Costs, Does Not "Relate To" Plans.

The commercials now argue that the health care assessments have a connection to plans because they have the purpose and effect of influencing ERISA plans' most basic administrative decision—the mechanism by which they provide health care coverage (Trav. Br. 17-18).

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attempt to cast themselves as the "surrogate" of employee benefit plans because they provide health care benefits to plan participants would transform all hospitals, clinics and doctors into employee benefit plans—an absurd result. (HMO Br. 20-24). State regulation of HMOs is simply not direct regulation of employee benefit plans.

Respondents' premise is the same as in the courts below, that the alleged "interference" is accomplished solely through the indirect and economic impact of the assessments on a plan's cost of providing benefits. The assessments impose no legal obligations upon plans and the economic impact on plan costs does not dictate or restrict plan conduct. At most, these laws affect plan choice through the economic regulation of the marketplace in which plans and other consumers of health care operate. Plans, and all other consumers, remain free to choose any method of providing benefits. That choice is not restricted by these assessments which, therefore, do not "relate to" plans.[6]

Moreover, even if the health care assessments had both the purpose and effect of influencing consumers by driving them to Blue Cross (Trav. Br. 16-17), a claim which New York has never conceded, and which cannot be supported on the record or the findings below,[7] the assess-

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[6] Contrary to the claims of the self-insured *amici* (Brief of National Carriers' Conference Committee ("NCCC") at 13; IFEBP Br. 12), this analysis applies equally to self-insured plans. The impact of the 13% differential is indirect because it directs hospitals to bill patients certain amounts, and self-insured plans have no obligation under state law to pay any part of the bill. The effect is still the economic one of possibly increasing plan costs.

[7] The record shows the following as to the various purposes of the assessments. Prior to 1983, when New York State began regulating the hospital rates of all payors and first enacted the differential (originally set at 15%), patients who had commercial insurance or were enrolled in self-insured funds paid from 25% to 40% more for hospital care than Blue Cross subscribers. (JA 149). *See* New York's main brief at 2-3. The purpose of the differential was to "level the playing field" by eliminating cost-shifting. (JA 165-66). The hospital charges paid by commercial insurers and self-insured funds were, thus, reduced to 15% more than Blue Cross paid. While the hospital charges paid by Blue Cross increased, they received a discount of 15% to compensate for the competitive disadvantage they sustained through the higher costs of open enrollment and community rating which only they (and to a lesser extent HMOs) used at the time. (JA 207). Thus, the 13% differential was not designed to influence consumers to choose any particular insurer, but

ments do not "relate to" plans. As urged in New York's main brief, there is a legally significant distinction between laws whose connection to plans is to dictate or restrict behavior, either directly through imposition of legal obligations upon them or indirectly through imposition of legal obligations upon others, and laws that may influence plan choice by affecting, through economic incentives, the marketplace in which plans purchase goods or services. (Main Br. 27). This distinction is not "sterile formalism," as the commercials claim (Trav. Br. 24). If state laws that do not directly or indirectly impose requirements on plans, but which may economically influence plan choices, are held to "relate to" plans, very few state laws would survive a preemption challenge. Virtually all state police power regulation has some economic impact on a marketplace and, therefore, may potentially influence the business choices of entities which operate in that marketplace. However, Congress did not preempt state laws that "might conceivably have an effect on plans," but only laws that "relate to" them.

In addition, the legislative history of ERISA demonstrates that Congress, when it enacted the preemption provision, was concerned with protecting ERISA plans' ability to conduct their multi-state operations uniformly, free from state "regulation," not from state-created influences. In *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85 (1983), the Court quoted the floor statements of the members of Congress who managed ERISA, all of which describe the final conference version of the preemption

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to prevent consumer choice from being artificially influenced by socially useful, but expensive, burdens. The 9% assessment was enacted to raise revenue and to encourage HMOs to enroll Medicaid recipients so that New York could contain its Medicaid costs. (JA 175-76). *See* Main Br. at 6. There is no evidence that the legislature ever considered what impact, if any, this assessment would have on HMO customers. The 11% surcharge was enacted to slow down Blue Cross' loss of all types of good risks from its community rated pools by making commercial insurance more expensive, and to raise revenue. (JA 155). *See* Main Br. at 5. Thus, only the 11% surcharge had the arguable purpose of influencing consumer choice.

provision as preempting laws that, directly or indirectly, *regulate* the operation of ERISA plans. 463 U.S. at 98-99. In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court again drew upon these statements to demonstrate that ERISA preemption was enacted to prevent states from subjecting plans to different "*regulatory requirements.*" 482 U.S. at 9 (emphasis added). The Court concluded: "Preemption ensures that administrative practices of a benefit plan will be governed by only a single set of *regulations.*" 482 U.S. at 11 (emphasis added).

To regulate is "to fix, establish, or control; to adjust by rule, method or established mode; to direct by rule or restriction; to subject to governing principles or law," Black's Law Dictionary 1451 (6th ed. 1990), in short to dictate or to restrict behavior. While ERISA preemption protects plans' freedom of choice as to their structure or administration from direct or indirect state regulation, it does not guarantee to plans a marketplace free from state-created economic influence. Therefore, laws which do not dictate or restrict plan choice as to structure or administration, either directly through the imposition of legal obligations on plans or indirectly through the imposition of legal obligations upon others, do not "relate to" plans.

For that reason, this case is very different from *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), upon which respondents place heavy reliance (Trav. Br. 24; HMO Br. 28-9), where the Court said a mandated benefit law "related to" plans. 471 U.S. at 479.[8] Notwithstanding respondents' claim to the contrary (Trav. Br. 19, HMO Br. 28), the Court showed no concern that the law might influence a plan's decision to become insured. Instead, the Court's concern was that the mandated benefit law indirectly dictated a plan term,

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[8] In *Metropolitan Life*, Massachusetts did not question whether the law "related to" plans. 471 U.S. at 749. Thus, the Court's discussion must be viewed in that context.

the coverage of mental illness, when plans chose commercial insurance. New York submits that, had the Massachusetts mandated benefit law permitted the sale of insurance policies without mental illness coverage, but instead had imposed a 13% surcharge on the cost of those policies (which insurance companies would pass on to those customers in the form of higher premiums), it would not "relate to" plans. Although such a surcharge would have the indirect economic impact of making those policies more expensive to plans, it would not dictate or restrict a plan's choice as to whether to provide mental health coverage.[9] In addition, it would make no difference in this hypothetical situation if Massachusetts' purpose in imposing the surcharge was to influence customers to buy a policy with mental health coverage, or was simply to raise revenue to operate its psychiatric hospitals.

In this case, plans are not required, even as an economic matter, to select any particular payor. Those plans which choose commercial insurance may pay more for hospital care than they would if they chose Blue Cross, but no plan terms are dictated or restricted thereby. Nor are the costs of the 13% differential or the 11% surcharge, which are part of a patient's hospital bill, even indirectly imposed upon plans, including self-insured plans. Even when plans choose what the commercials characterize as a "disfavored" payor (Trav. Br. 17), they still remain free from any state-imposed obligation to pay any particular amount of a hospital bill. If a plan chooses self-insurance over Blue Cross, a participant's hospital bill will amount to 113% of the diagnosis related group rate ("DRG"), N.Y. Pub. Health Law § 2807-c(1)(b), but the plan pays only according to its plan terms. When a

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[9] If a surcharge were so inordinately large, as in the example suggested by the commercials (Trav. Br. 24), that plans could demonstrate that it had the same effect as the mandated benefit law, *i.e.*, requiring insured plans to purchase a particular type of policy, the issue might arguably be different. However, such facts are not present in this case.

plan interprets or structures its plan terms to provide for payment of only the DRG rate, hospitals treat this no differently than any other limit on full payment of the bill by a third-party payor.[10] Thus, plans remain free, under state law, to avoid any adverse economic effect upon hospital costs which their choice of payor may involve.

Contrary to the HMOs' claims (HMO Br. 29), this case is not analogous to *Morales v. Trans World Airlines, Inc.*, —— U.S. ——, 112 S.Ct. 2031 (1992). The Airline Deregulation Act, involved in *Morales*, preempted state laws "relating to rates, routes or services." The purpose of the Act was to remove all regulation of airline rates and to promote " 'maximum reliance on competitive market forces' " which would "best further 'efficiency, innovation, and low prices'." *Morales*, 112 S.Ct. at 2034. In this context, certain states, pursuant to multi-state guidelines, imposed legal obligations upon the airlines' advertisement of discount fares. The airlines demonstrated, and the Court found, that there was a direct connection between their advertising and rates. *Morales*, 112 S.Ct. at 2039. The guidelines, however, did not simply make it more expensive to advertise rates, they severely restricted the airlines' ability to market reduced fares, and sometimes made it impossible to do so. *Morales*, 112 S.Ct. at 2040. Thus, the restriction on airline advertising had a significant and direct impact on fares, restricting the airlines' ability to utilize discount fares. There is no such direct economic restriction of

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[10] For example, at least one commercial insurer, Connecticut General, has made the determination that its plan terms do not permit payment of the 13% differential. (Rachlin Aff., Exh. D). In addition, one of the *amici* representing self-insured plans notes that some health plans would customarily prohibit payment of the 13% differential since that would not be considered a "medically necessary" expense. (Brief of The Self-Insurance Institute of America, Inc. at 13-14). In those cases, hospitals do what is customarily done when a third-party payor does not cover fully a patient's bill for whatever reason, *e.g.*, because of co-payments, deductibles, or the exclusion of certain charges or procedures. They bill the patient for the balance.

plan activities in this case. The *Morales* analogy to this case would be a state law that regulated the *price* of advertising, making it more expensive for airlines to advertise, but not restricting their ability to do so.

In this case, there are no claims, no findings, and no evidence that the indirect economic impact of the health care assessments on plans dictates or restricts plans' ability to structure or administer themselves. The commercials claim that the assessments interfere with a plan's choice of health care provider by imposing costs associated with some, but not all, providers of health care coverage (Trav. Br. 16).[11] The only pertinent evidence in the record is that these assessments may raise some plan costs above what they would be in the absence of the assessments.[12] There is no evidence of the competitive

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[11] The federal government already restricts that choice with respect to HMOs, by requiring all employers with more than 25 employees who provide health care coverage to offer HMOs as an option. 42 U.S.C. § 300e-9. Thus, the HMOs argue only that the 9% assessment interferes with plan structure through the imposition of higher costs which may result in fewer benefits, higher copayments, or both (HMO Br. 25-27).

[12] The record discloses the following. By April 1993, the 9% assessment had translated into an increase of 2.5% to 3.5% in some HMO rates. MetLife had been granted a 7.3% rate increase, effective January 1, 1992, none of which was attributable to the 9% assessment. It was granted a 3.3% rate increase, for the last three months of 1992, to account for the assessment. In January, 1993, MetLife was granted a 21.5% rate increase, 3.3% of which was attributed to the 9% (Rachlin Aff., Exh. A). Oxford Health Plans was granted a variable rate increase of 14.5% to 17.5% (depending upon if the full 9% was assessed) (Rachlin Aff., Exh. B). During that same period, Managed Health Inc., which was not being assessed the 9% because it enrolled its target number of Medicaid recipients, was granted a 12.32% rate increase (Rachlin Aff., Exh. C).

While the commercials claimed that 11% surcharge "put upward pressure" on their rates in 1992 (JA 138), they provided but one lone example of a plan whose rates were increased 7.3%, of which 2.5% was to reflect the surcharge. (JA 299). During the same time period, Empire Blue Cross' rates were increased a total of

impact which the assessments may have on the premiums or subscriber fees of the different types of health care coverage, and, therefore, no evidence of whether they actually influence plan choice.

Moreover, this argument has no merit because it ignores the different regulatory universes in which different providers operate. Blue Cross, HMOs, and the commercial insurers differ in many respects and, thus, are not regulated by the State in identical ways. These differing regulations also affect their costs differently. Self-insured funds are not regulated by the states and, as a result, are able to avoid all costs associated with direct state regulation. Therefore, the costs of different types of health care coverage are affected by many kinds of differing state regulation.

B. An Indirect Economic Impact Which May Influence Plan Choices Does Not "Relate To" Plans Merely Because Those Choices Concern Plan Structure And Administration.

Addressing the argument now made by respondents, the health care assessments do not "relate to" plans merely because the cost of providing benefits may influence choices regarding plan structure or administration. The commercials claim that uniform hospital rate regulation is not challenged in this case, but only "discriminatory" rate regulation because that influences a plan's choice of health coverage provider, its "most basic administrative decision." (Trav. Br. 18-19). The HMOs claim that since choice of

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26.7%, 14.2% in April, 1992, and 12.5% in October, 1992. (Clyne Aff., Exh. I). The commercials also claimed that the 13% differential represented 2% to 5% of premiums paid. (JA 300). However, when enacted, the differential resulted in decreasing hospital care costs, in an amount up to 18%, for commercials and self-insured funds who had faced unregulated cost-shifting (*infra*, p. 6 n.7). If the commercials had passed along any decrease in costs, it would have resulted in a premium reduction of up to 7%. Therefore, given this record, it cannot be concluded that any or all of the assessments, in fact, influence plan choice.

a health care benefit delivery system is a plan's most basic decision, these systems cannot be burdened by the State (HMO Br. 16, 22-24). Respondents support this assertion solely by reference to ERISA's definition of an employee benefit plan as providing enumerated benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). (Trav. Br. 17; HMO Br. 23). This reference does not elevate the choice of provider of benefits to a plan's most basic decision; it simply brings those employer programs which provide benefits by purchasing an insurance policy within the ambit of ERISA's coverage.[13] While the method of providing health care coverage is a basic administrative decision, it is no more basic than any other decision which may affect plan structure or administration, for example, whether to provide benefits, which benefits to provide, or upon what terms benefits will be provided (in terms of, *e.g.*, deductibles, co-payments, or excluded procedures).

Moreover, uniform regulation in the health care field may also influence those decisions. As New York previously demonstrated (Main Br. 24-25), to the extent that any uniform regulation of hospitals results in an increase in hospital costs, it may influence plans to eliminate health care benefits, eliminate or reduce inpatient benefits, or raise deductibles or copayments.[14] All regulation in

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[13] The self-insured *amici* make a similar claim tailored to their own interests. They argue that the choice between self-insurance and insurance is a most basic plan decision and, therefore, laws that have an indirect economic effect on this decision "relate to" plans. (NCCC Br. 12; *see also* IFEBP Br. 15). Under this theory, there could not be any state-created disincentives to self-insurance, even if there could be such disincentives as between various insurers.

[14] New York's regulation of residents and interns is a case in point. In 1988, New York implemented the first regulation of the working conditions of interns and residents in the country. These regulations, which limit the hospitals' ability to utilize this relatively inexpensive source of medical personnel, cost hospitals $120 million dollars in the first year of its enactment. (JA 186). These

the marketplace where employee benefit plans operate, which may have an economic impact upon the cost of providing benefits, may affect some plan choices as to structure or benefits. Indeed, the amici make the point that, as a result of increasing health costs, plans are altering their design by adopting larger deductibles and eliminating or reducing certain benefits. (IFEBP Br. 11; NCCMP Br. 15). Any state regulation in any benefit area, be it health care, day care, or prepaid legal services, which may increase the cost of providing benefits may well influence plans to alter some part of plan design. However, if plan choices are not restricted, a law will not otherwise "relate to" plans simply because the indirect economic impact on the cost of providing benefits may influence plan decisions concerning plan structure.

C. State Laws "Relate To" Plans Because Of Their Effect On Plans, Not Because Of Their Legislative Purpose.

The respondents also argue that the health care assessments are preempted because their interference with plan choices is "purposeful." (Trav. Br. 16, 19, 21; HMO Br. 16, 19-24). In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court rejected the notion that the purpose of the statute was relevant and, instead, examined its actual impact on plans. 451 U.S. at 524. The subjective intent of the legislature is not a dispositive factor if the law's impact is not, in itself, sufficient to "relate to" plans.[15] Laws which are designed to influence marketplace decisions economically do not "relate to" plans any more than laws which have an unrelated purpose but the same impact. The distinction between the 9% and the

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costs are reflected in higher hospital DRG rates. This increase in the cost of inpatient care may influence plans to cut back or even drop inpatient care benefits.

[15] If the intent of the law is to influence only ERISA plans, then the law will probably refer to or depend upon the existence of employee benefit plans and be preempted on that basis.

11% suffices to make this point. The subjective intent of the legislature, in enacting the 9% assessment, was to influence HMO behavior, not HMO customer behavior (JA 37, 52). The purpose was to encourage HMOs to enroll a target number of Medicaid recipients and also to raise revenue.[16] The 11% surcharge was enacted in an attempt to influence marketplace behavior by stemming the migration of Blue Cross subscribers to the commercials. The impact of the 9% assessment upon the plans that are affected has been a 2.5% to 3.5% rate increase. (JA 1555). This is identical to the impact upon plans that are affected by the 11% differential, which the commercial insurers demonstrated had resulted in a 2.5% rate increase to at least one plan. (JA 299). Thus, the commercials cannot distinguish the Third Circuit's decision in *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital,* 995 F.2d 1179 (3d Cir.), *cert. denied,* 114 S.Ct. 382 (1993), on the basis that New York seeks to influence plan behavior while New Jersey did not have that purpose. (Trav. Br. 21 n.11). New Jersey's hospital rate-setting statute included surcharges imposed on commercial insurers and self-insured funds and discounts given to plans which had open enrollment. The combined effect of the surcharges and discounts was a 13% differential in favor of Blue Cross. 995 F.2d at 1189-90. The impact on plans and the incentive to switch to Blue Cross coverage is the same under both statutes.

III. THE HEALTH CARE ASSESSMENTS DO NOT INTERFERE WITH MULTI-STATE UNIFORMITY.

Respondents acknowledge that the costs of providing benefits and the costs of the various types of health care

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[16] Although the HMOs rely on "purposeful interference" in the context of the 9% assessment, it is clear from the HMOs' brief (p. 16) and the record that, while the legislature purposefully imposed the 9% on HMOs, there was no legislative purpose to interfere with plan choice. (Main Br. 6).

coverage vary from place to place due to "market factors". (Trav. Br. 23). Indeed, the record in this case demonstrates that the very evil which respondents decry, payor differentials in hospital rates, exists in unregulated markets. (JA 190). Faced with these facts, the respondents can only respond that ERISA bars "state-created" variations in costs. (Trav. Br. at 23). However, this response begs the critical question of whether preemption of these laws furthers the Congressional purpose of enabling multi-state plans to operate uniformly. If the state to state costs of benefits, and the costs of various types of health care coverage, are not uniform even in the absence of preemption, then preemption of these laws would fulfill no Congressional purpose.

Moreover, all state regulation affects multi-state uniformity to the same extent. Like other businesses, ERISA plans do not operate in a marketplace free from state regulation. In their capacity as providers of various types of employee welfare benefits, ERISA plans purchase goods and services, on behalf of themselves or on behalf of their participants, from hospitals, doctors, dentists, pharmacies, medical laboratories, attorneys, banks, securities dealers, commercial insurance companies, not-for-profit health service corporations, day care providers, and HMOs. All of these entities are subject to a variety of state laws and regulations which affect the cost of their goods or services. As each of these entities is regulated somewhat differently in each state, costs will necessarily vary.[17] Thus, plan costs vary because of differences in many kinds of state regulation which may have no connection to plans other than to affect plans' costs.

The only way to free plans from "state-created" variations in costs would be to preempt all state regulation

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[17] As the *amici* make clear, even uniform hospital rate regulation can and does vary from state to state, resulting in varying costs. (IFEBP Br. 12-13).

which has an impact on cost in any benefit area. Indeed, the HMOs and some *amici* argue that ERISA was designed to preserve a free marketplace for benefit delivery systems. (HMO Br. 14-15; IFEBP Br. 3-5). In this world view, all state regulation of HMOs, commercial insurers, and Blue Cross which increases their costs "relates to" plans.

There is nothing in ERISA's language, structure, or legislative history that supports the view that Congress intended to guarantee ERISA plans a free marketplace in which to operate.[18] Moreover, this "free marketplace" theory is contrary to *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 741, where the Court noted that laws which regulate only an insurer or how it sells insurance do not "relate to" plans. Yet, those laws have an economic impact on insurer premiums. The Court and Congress clearly did not envision that commercial insurers or HMOs would operate in a marketplace free from state regulation.[19]

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[18] Indeed, a comparison of ERISA legislative history and the legislative history of the Airline Deregulation Act, which was designed to guarantee airlines a free marketplace in which to set rates, demonstrates that when Congress intends to guarantee a free marketplace, it says just that. *Morales v. Trans World Airlines, Inc.*, 112 S.Ct. at 2034.

[19] New York relies upon and adopts the arguments contained in the Reply Brief of the New York Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield as to the application of the "insurance savings" clause. However, on the issue of whether the "deemer" clause is implicated in this case, New York adheres to its position that it is not implicated because the district court enjoined enforcement of the assessments, which are imposed depending upon the payor of the hospital bill, against the commercial insurers and HMOs only. They are the only plaintiffs in this case who are payors of hospital bills. The deemer clause is not implicated in a situation where a self-insured group itself does not pay hospital bills. No appeal from the district court's judgment was filed on behalf of the self-insured funds whose bills are paid by commercial insurers. In any case, neither the district court

CONCLUSION

For the reasons set forth herein and in New York's main brief, the Court should reverse the judgment below.

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nor the Second Circuit ruled on the issue and, should the Court determine that the "deemer" clause issue is presented, the issue should be remanded to the Second Circuit.

Nos. 93-1408, 93-1414 and 93-1415

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

MARIO M. CUOMO, GOVERNOR OF NEW YORK, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

HOSPITAL ASSOCIATION OF NEW YORK STATE, PETITIONER

v.

TRAVELERS INSURANCE CO., ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

In three related statutes, New York State law imposes different surcharges on the rates hospitals charge, depending on whether the charges are paid by commercial insurers, health maintenance organizations, self-insured funds, or other specified payors. The question presented is:

Whether the surcharges, which apply to hospital care regardless of whether it is provided pursuant to a plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), are preempted by ERISA insofar as the hospital charges are covered by an ERISA plan.

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In the Supreme Court of the United States

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No. 93-1408

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

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v.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

This case presents questions concerning the scope of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001-1169 (1988 & Supp. V 1993). See 29 U.S.C. 1144. The Secretary of Labor is primarily responsible for enforcing and administering Title I of ERISA. See 29 U.S.C. 1002(13), 1136(b). The United States therefore has a substantial interest in the resolution of the question presented. In response to the Court's invitation, the United States filed a brief at the petition stage of this case urging that certiorari be granted.

STATEMENT

1. New York State has a "comprehensive statutory scheme for the regulation of in-patient hospital rates." Pet. App. A64-A65.[1] For each of 794 diagnostic related groups (DRGs), a uniform rate is set that reflects the average cost of treating a patient with a particular condition, adjusted for each hospital to reflect factors such as its operating costs, capital costs, malpractice costs, and bad debt and charity care costs. In general, patients admitted to a hospital are assigned a DRG according to their condition, and are billed at the DRG rate for that particular hospital, rather than for the actual cost of treatment. *Id.* at A65.

In 1988 and 1992, the New York Legislature enacted laws requiring that hospital rates be calculated according not only to the DRG rate for the patient and hospital, but also according to who was paying for the services. The legislation prescribed three surcharges to be added to hospital rates:

First, a 13% surcharge was imposed on all hospital bills paid by a commercial insurer, by a "self-insured

[1] All references to "Pet. App." are to the appendix to the petition for a writ of certiorari in No. 93-1414.

fund" that directly reimburses hospitals, or by certain workers' compensation, volunteer firefighters' and ambulance workers' benefits, and no-fault motor vehicle insurance funds. N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993) (*reproduced at* Pet. App. A102-A103). The surcharge is paid to the hospital and retained by it.

Second, an additional surcharge of 11% was imposed on hospital bills paid by commercial insurers, raising the total surcharge for such payors to 24%. N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney 1993) (*reproduced at* Pet. App. A104). That surcharge was to be collected by hospitals, which were then to pay it into the State's general fund. The 11% surcharge was in effect only for a one-year period ending on March 31, 1993. *Ibid.*

Third, rates for services rendered to a member of a health maintenance organization (HMO) were surcharged 0% to 9%, depending on how close the member's particular HMO came to meeting a prescribed target for enrollment of Medicaid recipients.[2] N.Y. Pub. Health Law § 2807-c(2-a)(a)-(e) (McKinney 1993) (*reproduced at* Pet. App. A106-A113). The 0% to 9% surcharge is paid by the HMO directly into a statewide pool, and then into the State's general fund. N.Y. Pub. Health Law § 2807-c(2-a)(c)(i) (McKinney 1993) (*reproduced at* Pet. App. A111). See Pet. App. A65.

Some hospital bills are not subject to any surcharge. Services covered by Medicaid or by a Blue Cross/Blue Shield plan (the Blues) are billed at the DRG rate without a surcharge. N.Y. Pub. Health Law § 2807-c(1)(a) McKinney 1993) (*reproduced at* Pet. App. A101). Serv-

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[2] The Medicaid program, established by Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, provides federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons. See, *e.g.*, *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36-40 (1981).

ices rendered to all other patients, including those patients who pay their own bills or who are reimbursed directly by self-insured funds or commercial insurers, are subject to the hospital's charges (not the DRG rate), with a statutory limit higher than that charged to commercial insurers. N.Y. Pub. Health Law § 2807-c(1)(c) (McKinney 1993) (*reproduced at* Pet. App. A103).

The purpose of the 13% surcharge is "to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers" by making the Blues—traditionally the "insurer of last resort" for high-risk individuals, see Pet. App. A28—more competitive with commercial insurers. *Id.* at A7-A8. The 11% surcharge has a similar purpose, and also was designed to increase state revenues. *Id.* at A8, A22, A72-A73 & n.8. "[T]he primary purpose of the [0% to] 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program." *Id.* at A7-A8.

ERISA welfare plans pay for a large percentage of hospital bills in New York State. Pet. App. A6. "ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills * * *; (3) subscription to a health maintenance organization * * *; and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans." *Id.* at A6-A7. Thus, ERISA plans that provide hospitalization benefits either are purchasers of hospitalization coverage from commercial insurers or other payors, or are themselves payors of hospital bills.

2. This case presents the question whether the 13%, 11%, and 0% to 9% surcharges are preempted by ERISA. ERISA generally governs employee benefit plans, see 29 U.S.C. 1003(a), including any employee welfare benefit plan "established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or

otherwise, * * * medical, surgical, or hospital care or benefits." 29 U.S.C. 1002(1).

ERISA plans that provide benefits for participants by purchasing medical coverage—such as from commercial insurers, the Blues, or HMOs—are "insured plans." Plans that pay for participants' benefits out of the general assets of an employer's business are "self-insured plans," see *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 732 (1985), as are many multiemployer health plans. See 29 U.S.C. 1002(37) (1988 & Supp. V 1993); 26 U.S.C. 414(f). But not every arrangement by which an individual or group obtains health coverage is an ERISA covered plan. A plan subject to ERISA must be established by an "employer" or "employee organization" for the purpose of providing certain benefits to its "employee[s]." 29 U.S.C. 1002(1), (4)-(6). Health coverage obtained through arrangements that are unrelated to employment or based on an employment relationship that does not satisfy ERISA's coverage provisions is not covered by ERISA. See 29 U.S.C. 1003(b) (exclusion for governmental, church, and some other plans); cf. *Fugarino* v. *Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992) (sole proprietor), cert. denied, 113 S. Ct. 1401 (1993).

Section 514(a) of ERISA is an express preemption provision, which states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. 1144(a). The insurance savings clause of ERISA, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), however, limits the reach of the preemption clause. The savings clause states that, except as provided in the "deemer clause," described below, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." See App., *infra*, 1a. Thus, a law that "relates to" an ERISA-covered plan is not preempted if it is a law "which regulates insurance."

Finally, the savings clause is, in turn, limited by the "deemer clause" of ERISA, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B). That clause distinguishes between "an insurance company or other insurer * * * engaged in the business of insurance," to which the savings clause applies, and "an employee benefit plan," which shall not be "deemed" to be an insurance company or engaged in the business of insurance for preemption purposes. See App. *infra*, 1a. Thus, a state law that "relates to" an employee benefit plan that self-insures is preempted, even if such a law would otherwise be saved from preemption as a law "which regulates insurance." See *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61-63 (1990).

3. In two actions later consolidated, respondent insurance companies and their trade associations sought to invalidate and enjoin enforcement of the three New York surcharges on grounds that the surcharges are preempted by ERISA. The other respondents (including the New York State Health Maintenance Organization Conference and several HMOs) intervened in support of the insurers, and the New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York State intervened in support of the state defendants.

On cross-motions for summary judgment, the district court held that ERISA preempts all three surcharges, Pet. App. A63-A90, and it enjoined their enforcement "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." *Id.* at A89-A90. The court reasoned that the surcharges "relate to" ERISA plans because they impose "a substantial economic burden on the commercial insurers and HMOs," which affects the behavior of ERISA plans when it is passed on to them in the form of increased costs for health coverage. *Id.* at A71, A73. The court also concluded that none of the surcharges is saved as a law that regulates insurance under ERISA's insurance savings clause. *Id.* at A79-A80.

4. The court of appeals affirmed the district court's ruling that ERISA preempts all three surcharges. Pet. App. A17-A29, A34. The court held that, although the surcharge statutes "do not refer to ERISA plans," they "relate to" ERISA plans within the meaning of Section 514(a) because they "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand* [*Co.* v. *McClendon*, 498 U.S. 133 (1990)]." Pet. App. A22. The court found the requisite connection in the fact that, because the surcharges were designed to increase hospital costs for patients not covered by the Blues, "the surcharges purposely interfere with the choices that ERISA plans make for health care coverage." *Ibid.* Additionally, the court observed that "[t]he surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," forcing them "to increase either plan costs or reduce plan benefits." *Id.* at A23. The court rejected the argument that indirect economic impact alone does not suffice to justify a finding of preemption. *Id.* at A23-A24.

The court also ruled that the 11% and 13% surcharges are not saved from preemption under Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), as laws "which regulate[] insurance." Reasoning as did the district court, the court held that the surcharges are not insurance laws as a matter of "common-sense" because they regulate hospital rates and are not directed at the insurance industry. Pet. App. A26-A27. The court rejected the argument that laws "designed to affect the insurance marketplace by giving the Blues a competitive advantage over * * * other players in the marketplace" amount to regulation of the "business of insurance," which the court believed to be the exclusive focus of ERISA's insurance savings clause. *Id.* at A27.

The court reached the same result applying the three factors considered under the McCarran-Ferguson Act, 15 U.S.C. 1011-1015, which this Court has held relevant to the determination whether a state law is saved under

ERISA's insurance savings clause. See, *e.g.*, *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48-49 (1987). The court found that the 11% and 13% surcharges spread risk, and thus satisfy the first factor, by encouraging customers to shift to the Blues. Pet. App. A28. In the court's view, however, the second factor is not satisfied, because the surcharges "do not regulate any practice that is integral to the insurer-insured relationship." *Ibid.* The court reasoned that the surcharges "relate only to the contractual obligations between hospitals and insurers or insureds," rather than the relationship between the insurers and insureds. *Id.* at A29. Finally, the court held that the third factor is not satisfied, reasoning that the surcharges are not "limited to entities within the insurance industry" because the 11% and 13% surcharges affect non-insurance entities such as "the State, hospitals, patients, HMOs, and self-insured funds." *Ibid.* In two footnotes, the court approved the district court's holding that the 0% to 9% surcharge affecting only HMOs is not saved because HMOs do not engage in the business of insurance "as a matter of law." *Id.* at A26 n.5, A29 n.6.

SUMMARY OF ARGUMENT

New York State's surcharges do not "relate to" ERISA plans, because they are laws of general applicability that have only an indirect, economic effect on ERISA plans that purchase insurance and do not affect the interstate operation of such plans. Each of the surcharges is a law of general applicability, because it applies to broad categories of payors, each of which was intended to and does include both ERISA plans and participants and non-ERISA plans and participants. The impact of the surcharges on ERISA plans is indirect (since the surcharges apply to health insurance carriers, not insured ERISA plans themselves) and purely economic (since the surcharges affect only the costs of services ERISA plans purchase). The surcharges are unlikely to have any effect

on the interstate operation of ERISA plans, since hospital rates in any event vary widely within New York State and between New York and other States.

The court of appeals held that the surcharges were preempted, primarily because they "impose a significant economic burden on commercial insurers and HMOs * * * [and] therefore have an impermissible impact on ERISA plan structure and administration." Pet. App. 24. ERISA, however, does not preempt a state law simply because it causes the marketplace to provide certain economic incentives to ERISA plans to provide certain types of benefits to employees. Any form of regulation of hospital costs provides an incentive to purchasers of hospital care to tailor their conduct accordingly. A state regulation does not relate to plans so long as its only effect is to subject all buyers in a broad-based market in which ERISA plans and others substantially participate to a single set of marketplace incentives.

Even if the court of appeals were correct that the surcharges "relate to" ERISA plans, the court nonetheless erred in holding that the 11% and 13% surcharges are not saved by ERISA's insurance savings clause. The language of that clause is somewhat broader than the corresponding language of the McCarran-Ferguson Act. It is therefore appropriate to read the ERISA savings clause to save a somewhat broader range of state insurance regulation.

In this case, as a matter of "common sense," the surcharges on commercial insurers and HMOs are laws that regulate insurance. Although the surcharges are collected through the mechanism of hospital rates, their incidence is determined entirely by reference to the payor's status in the insurance industry. In addition, they are designed to give the Blues a rate advantage in the marketplace, thereby encouraging more customers to purchase coverage from the Blues and helping maintain the solvency of the Blues. The intended effects of the surcharges are there-

fore the traditional effects of insurance regulation—spreading risk, setting rates, and maintaining the solvency of insurers.

The same conclusion follows from an analysis of the three factors used to determine whether state regulation falls within the McCarran-Ferguson Act. As noted above, the surcharges serve a vital function in spreading risk. In addition, they affect the contract between insurer and insured because they are premised on the open-enrollment and community-rating policies of the Blues and HMOs, and their intended effect is on contract formation—to make hospitalization coverage more widely available at lower cost. Finally, the surcharges are generally limited to entities within the insurance industry, since their primary effect is on such entities.

ARGUMENT

A. THE SURCHARGE STATUTES DO NOT "RELATE TO" THE ERISA PLANS IN THIS CASE UNDER SECTION 514(a) BECAUSE THEY ARE GENERALLY APPLICABLE LAWS HAVING AN INDIRECT AND SOLELY ECONOMIC EFFECT ON ERISA PLANS

ERISA supersedes all state laws that "relate to" an ERISA plan. 29 U.S.C. 1144(a). A law "relates to" such a plan for purposes of Section 514(a) if it "has a connection with or reference to such a plan." *District of Columbia* v. *Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Section 514(a)'s preemptive reach is "conspicuous for its breadth." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990). Thus, a state law may "relate to" an ERISA plan "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Ingersoll-Rand Co.* v. *McClendon*,

498 U.S. 133, 139 (1990)); see *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). The pre-emptive reach of Section 514(a) is not, however, unlimited. The fact that the operation of a state law "might burden the administration of a plan [does] not, by itself, compel pre-emption." *Ingersoll-Rand*, 498 U.S. at 139. In addition, "[s]ome state [laws] may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to'" ERISA plans, *Shaw*, 463 U.S. at 100 n.21, "as is the case with many laws of general applicability." *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n.1. In this context, "a generally applicable statute" is one "that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.

1. Each of the New York statutes imposing surcharges on hospital bills paid by HMOs and commercial insurers is a law "that makes no reference to, [and] indeed functions irrespective of, the existence of an ERISA plan," *Ingersoll-Rand*, 498 U.S. at 139, and that has an effect too "tenuous, remote, or peripheral" on employee welfare benefit plans to "relate to" them within the meaning of Section 514(a), *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n.1. The surcharges are laws of general applicability because they apply to categories of payors—commercial insurers, HMOs, self-insured funds, etc.—that are defined without regard to whether they provide health benefits for ERISA plans or participants in ERISA plans.[8] Moreover, each of the affected categories of

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[8] "Self-insured fund[s]" are among the enumerated payors of hospital bills subject to the 18% surcharge. Such funds include, but are not limited to, self-insured ERISA-covered plans. In our brief at the petition stage of this case, we stated that no self-insured fund is a plaintiff in this case. See Br. 14 n.5, 15 n.7 In

payors, as well as the Blues, in fact provides health coverage for both ERISA and non-ERISA plans and participants.

The only impact that the surcharges have on ERISA plans is indirect (because the surcharges do not apply to

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fact, the complaints filed in this case may be read to allege that one or more of the plaintiffs is a self-insured plan, see J.A. 93, at ¶ 18, and the complaints allege that several of the insured-plaintiffs in this case are fiduciaries for self-insured funds that are ERISA plans, see J.A. 69, 91-93.

The injunction in this case precludes enforcement of the surcharge "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." Pet. App. A89-A90. It is not clear that the district court's injunction, which bars application of the surcharge in connection with the insurers' "coverage" of ERISA plans, applies to situations in which commercial insurers serve as administrators of plans but do not extend insurance coverage to them. In any event, the injunction was not directed at self-insured plans generally. As we explained in our brief at the petition stage of this case at 14 n.5), "[a]pplication of the 13% surcharge to 'self-insured funds' may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves." Cf. 29 U.S.C. 1144(b)(5) (1988 & Supp. V 1993) (exempting Hawaii prepaid health care act from preemption, but stating that provision shall not be construed to exempt from 29 U.S.C. 1144(a) "any State tax law relating to employee benefit plans"). Therefore, the discussion in the text throughout addresses only insured plans.

Since no cross-appeal was taken from the district court's order, the application of the 13% surcharge to "self-insured fund[s]" was not raised by any party before the court of appeals. Nor did the court address it *sua sponte*. Therefore, if this Court agrees with our submission that the 13% surcharge is not preempted with respect to other entities to which it applies, the Court should not decide the question of the application of the surcharge to self-insured plans. Instead, the court should remand to the court of appeals (and, if necessary, to the district court) to determine in the first instance whether that issue is properly presented in this case and, if so, how it should be resolved in light of this Court's decision.

insured plans themselves, but are generally applicable to insurers and other health carriers whose services are purchased both by ERISA plans and others) and solely economic (because the surcharges affect only the costs of services ERISA plans purchase). The surcharges neither prescribe nor proscribe what hospitalization or other benefits a plan must afford; the eligibility standards for those benefits; the level of benefits offered; or the method of calculating benefits. The surcharges impose no substantive obligations on plans, and do not require them to conduct their administrative affairs in any particular way. Compare *Greater Washington Bd. of Trade, supra* (preempting statute mandating benefits to employees receiving workers' compensation that were tied directly to level of benefits set by plans); *FMC Corp., supra* (preempting law barring plans from enforcing subrogation claims on benefits); *Alessi, supra* (preempting law prohibiting plans from applying certain offsets to benefits).

Finally, the surcharges do not impede the interstate operation of ERISA plans, which ERISA's preemption clause was principally designed to protect. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987). The surcharges merely affect the calculation of fees paid for hospital care. Like other costs of doing business, those fees vary in any event from hospital to hospital and from region to region. In this respect, the surcharges are indistinguishable from any "state regulation under the police power which result[s] in increases in the cost of doing business" for plans. *United Wire, Metal & Machine Health & Welfare Fund* v. *Morristown Memorial Hosp.*, 995 F.2d 1179, 1196 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993).

2. It is our submission that ERISA does not preempt state laws of general applicability that have *only* an indirect, economic effect on ERISA plans and do not

impede the interstate operation of such plans.[4] The court of appeals reached the contrary conclusion primarily on the ground that, in its view, "the surcharges purposely interfere with the choices that ERISA plans make for health care coverage." Pet. App. A22. In the court's view, "[t]he surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," forcing them "to increase either plan costs or reduce plan benefits." *Id.* at A23. That kind of impact, however, is insufficient to trigger preemption.

a. This Court has never held that a generally applicable state law that has a merely indirect, economic impact on ERISA plans is preempted under ERISA. To the contrary, in each case in which the Court has found preemption, the effect of the state law was either not indirect or not solely economic. For example, in *FMC Corp.*, 498 U.S. at 60, the Court held preempted a state statute regulating employee benefits plans that "prohibit[ed] [such] plans from being structured in a manner requiring reimbursement in the event of recovery [by a plan member] from a third party"; the statute's effect was thus both direct and not solely economic. In *Greater Washington Bd. of Trade*, 113 S. Ct. at 583, the Court held preempted a statute that "specifically refer[red] to welfare benefit plans regulated by ERISA" and that tied the level of state workers' compensation benefits to the level of benefits provided in the plans; its effect on such

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[4] In the court of appeals, the Secretary of Labor, appearing as amicus curiae, expressed the view that indirect economic impact is not a sufficient basis for ERISA preemption, but that the impact on choices made by plans provides a sufficient connection to trigger preemption. The Secretary took the position that the surcharges "relate to" ERISA plans on that narrow ground, but that—except for self-insured ERISA plans, which are protected by the "deemer" clause—they are saved from preemption by the insurance savings clause. The position stated in text is now the position of the Secretary.

plans was therefore direct. In *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987), the preempted common law cause of action was for damages arising from the improper processing of a claim for plan benefits, see *id.* at 48; it was preempted because it imposed administrative requirements directly on ERISA plans. Finally, in *Shaw*, 463 U.S. at 96-98, the preempted statute directly imposed requirements that employee benefit plans pay certain specified benefits and that they not discriminate on the basis of pregnancy.

Where it has expressly addressed the issue, this Court has been careful to distinguish the case of indirect, solely economic impact from the closer relation required to trigger ERISA preemption. For instance, in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831 (1988), the Court acknowledged that Georgia's general garnishment statute would impose "substantial administrative burdens and costs" on ERISA plans. But the Court nonetheless held that the garnishment statute was not preempted. In *Ingersoll-Rand*, a wrongful discharge law that permitted a cause of action "premised on[] the existence of a * * * plan" did more than simply add an additional "cost" to the plan's "administrative burden." 498 U.S. at 139-140.[5]

Similarly, this Court found more than a merely indirect and economic impact before concluding that a law man-

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[5] Although this Court observed in *Alessi*, 451 U.S. at 525, that "even indirect state action bearing on private pensions may encroach upon" ERISA plans, the reference was to a New Jersey workers' compensation statute that by its terms prohibited plans from offsetting compensation awards against pension benefits. The statement was simply a reiteration of the principle that a statute need not be denominated a "pension regulation" in order to "relate to" pension plans. *Ibid.* In any event, it was clear that the New Jersey statute had more than a merely economic effect on ERISA plans; the statute did not merely give the plan an incentive to act, but rather "eliminate[d] one method for calculating pension benefits * * * that is permitted by federal law." *Id.* at 524.

dating insurers to include mental health benefits in their policies "clearly 'relate[s] to' welfare plans governed by ERISA." *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985). In that case, the Court implicitly recognized a legally significant difference between a law that substantially dictates an ERISA plan's choice of which benefits to provide participants by compelling insured plans to "purchase the * * * benefits specified in the statute when they purchase a certain kind of common insurance policy," *ibid.*, and a law that affects a plan's choice of benefits only by affecting the price of insurance purchased both by ERISA plans and by others in the State, see *id.* at 741 ("laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance").

b. The consequence of adopting the court of appeals' theory of preemption based on mere indirect, economic impact would be both substantial and unwarranted. The court of appeals relied on the fact that the surcharges interfere with the choices made by ERISA plans. Pet. App. A22. But they do so in only one way: by increasing the relative cost of purchasing hospitalization coverage from some carriers, the surcharges make it less desirable for ERISA plans—along with anyone else purchasing health coverage in New York—to purchase coverage from those carriers.

The court of appeals' reasoning leads directly to the conclusion that ERISA plans are entirely exempt from the effects of any significant state regulation of the health care marketplace, for the court rested its conclusion on the existence of a type of interference with plan choice that is inherent in *any* form of regulation of hospital or medical costs.[6] For example, insofar as the DRG cate-

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[6] In a more recent decision, the court of appeals acknowledged the breadth of its preemption theory. The court explained that a law that "targets only the health care industry," which "by defini-

gories themselves increase the costs of treatment for a particular medical condition, they provide a disincentive to ERISA plans to purchase insurance that provides coverage for that condition. And insofar as a given hospital is permitted, under the DRG system, to charge more than another hospital for the same service, the system provides a disincentive to plans to purchase insurance that provides benefits at the more expensive hospital. Indeed, even a state regulation, such as a tax, that resulted in an across-the-board increase in the costs of hospitalization would provide an incentive to ERISA plans to limit the hospitalization coverage they provide and to offer alternative benefits—either medical benefits or other types of employee benefits—instead.

Nor is the problem limited to cases in which state regulation increases the costs of some procedures, or of some hospitals, or of hospital costs generally. State regulation of ERISA plans is preempted whether it favors or disfavors such plans. See *Mackey*, 486 U.S. at 829-830. Thus, even state regulation that succeeded in *lowering* hospital costs for a given procedure, a given hospital, or hospital procedures in general would be found, under the court of appeals' theory, to "relate to" ERISA plans, since such regulation would provide an incentive for ERISA

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tion" is "the realm where ERISA * * * plans must operate," is "bound to affect" ERISA plans and thus "relate to" them. *NYSA-ILA Medical & Clinical Servs. Fund* v. *Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994), petition for cert. pending, No. 94-745 (filed Oct. 21, 1994). The district court too acknowledged that, under this test, all state hospital rate-setting statutes will "relate to" employee benefit plans—and hence will be subject to ERISA preemption—insofar as "they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." Pet. App. A77-A78; cf. *New England Health Care Employees Union Dist. 1199* v. *Mount Sinai Hosp.*, 846 F. Supp. 190, 195-198 (D. Conn. 1994) (relying on the Second Circuit's decision in this case to hold that ERISA preempts portions of Connecticut's hospital cost regulatory scheme), appeal pending, Nos. 94-7264 & 94-7906 (2d Cir.).

plans to alter their benefits packages and thus would interfere with the choices that ERISA plans make. Pet. App. A22.

Insofar as the surcharges at issue in this case affect plan choice, they do so only by subjecting ERISA plans to the same sort of marketplace incentives to which all other purchasers of health coverage are subject. So long as ERISA plans are subject to the same marketplace incentives as other purchasers of health coverage in New York, the fact that those incentives stem to some degree from generally applicable laws passed by the State—rather than from an entirely hypothetical free market in health care—is insufficient to preempt those state laws.

There is nothing in the text of the ERISA preemption clause, its legislative history (see *Shaw*, 463 U.S. at 99-100), or this Court's decisions construing the clause, to support a broad exemption for ERISA plans from the indirect and solely economic effects of generally applicable state laws on the health care marketplace. It is true that a large portion of the State's hospital bills are ultimately paid for by ERISA plans.[7] But the fact that ERISA plans are among the major participants in the health care marketplace does not convert regulation of that marketplace (for legitimate purposes unrelated to ERISA plans) into regulation that "relates to" ERISA plans.

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[7] The court of appeals noted that "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans." Pet. App. A6. That figure is overstated and appears in any event to exclude non-elderly Americans who are uninsured. Nationwide, the percentage of nonelderly covered by employer-provided plans in 1992 (the most recent year for which figures are available) was 62.5%; that percentage, which includes participants in non-ERISA covered governmental and church plans, drops to 58.8% if the elderly are included. Employee Benefit Research Institute Issue Brief No. 145: *Special Report: Sources of Health Insurance and Characteristics of the Uninsured* 5 (Table 1) (Jan. 1994). In addition, because of deductibles, copayments, exclusions, and limitations, participants in ERISA-covered plans pay for a portion of their own hospital bills.

B. THE SURCHARGE STATUTES ARE IN ANY EVENT SAVED FROM PREEMPTION IN THIS CASE AS LAWS WHICH REGULATE INSURANCE

Having concluded that the 11% and 13% surcharges "relate to" ERISA plans, the court of appeals concluded that those surcharges are not saved by the ERISA insurance savings clause. In our view, the court erred in reaching that conclusion as well.[8]

1. ERISA's insurance savings clause, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), "substantially qualifie[s]" Section 514(a)'s otherwise broad preemption of state laws that "relate to" ERISA covered plans. *Metropolitan Life*, 471 U.S. at 733. The savings clause states that, except as provided in the "deemer clause," 29 U.S.C. 1144(b)(2)(B), ERISA does not "exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). Thus, a law that regulates insurance is saved from preemption even if it "relate[s] to" ERISA plans. *FMC Corp.*, 498 U.S. at 61.

a. The determination of whether a state law regulates insurance within the meaning of ERISA's savings clause is largely a matter of "common-sense." *Metropolitan Life*, 471 U.S. at 740. "A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact

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[8] The court of appeals found—incorrectly, in our view—that HMOs "do not engage in the 'business of insurance' as a matter of law." Pet. App. A29 n.6. It therefore did not reach the further question of whether the particular characteristics of the 0% to 9% surcharge, which has a stated purpose different from that of the other surcharges (see p. 4, *supra*), render it a "law * * * which regulates insurance" within the meaning of the insurance savings clause. In our view, a law regulating HMOs *can* constitute a "law * * * which regulates insurance" under some circumstances. See pp. 25-26, *infra*. We understand, however, that no party argues in this case that the 0% to 9% surcharge is saved as a law that regulates insurance. This Court accordingly need not address that issue.

on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50 (general tort law applicable to, but not specifically directed toward, insurance industry not saved from preemption); accord *FMC Corp.*, 498 U.S. at 61 (state law must be "aimed at" the insurance industry, "not merely have an impact on" it).

Because "[t]he ERISA saving clause * * * appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States," *Metropolitan Life*, 471 U.S. at 744 n.21, the three criteria used to determine the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012 (discussed at pp. 7-8, *supra*, and 24-27, *infra*), are also relevant in determining whether a law "regulates insurance" under ERISA. *Metropolitan Life*, 471 U.S. at 743. As in a McCarran-Ferguson Act case, however, "[n]one of these criteria is necessarily determinative in itself," *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982), and indeed, a law may be found to be an insurance law under ERISA's savings clause without resort at all to the *Pireno* factors. See *FMC Corp.*, 498 U.S. at 61 (finding that a law precluding subrogation is an insurance law, without mention of the *Pireno* factors).

b. Although this Court has recognized the relevance of analysis under the McCarran-Ferguson Act to questions regarding the scope of ERISA's insurance savings clause, it does not follow that the analysis is precisely the same under both statutes. Above all, consideration of whether a law "regulates insurance" under ERISA, while guided by "common sense" and the *Pireno* factors, must also be informed by "the role of the savings clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 51. Indeed, the language of ERISA's insurance savings clause (as illuminated by the deemer clause) suggests that its sweep is somewhat broader than that of the McCarran-Ferguson Act.

The McCarran-Ferguson Act distinguishes between the "business of insurance," which it exempts from federal preemption, and the "business of insurance companies," which it does not exempt from federal preemption. *Hartford Fire Ins. Co.* v. *California*, 113 S. Ct. 2891, 2901 (1993); *SEC* v. *National Sec., Inc.*, 393 U.S. 453, 459 (1969). Under traditional McCarran-Ferguson Act analysis, not everything an insurance company does is within the "business of insurance." See *Pireno, supra* (use of chiropractic organization to provide peer review); *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979) (cost-saving arrangements with pharmacists).

In contrast, the ERISA savings clause is best read as encompassing insurance regulation generally. By its terms, the savings clause broadly states that ERISA does not exempt "any person from any law of any State *which regulates insurance*." 29 U.S.C. 1144(b)(2)(A) (emphasis added). That language suggests a broader sweep than the McCarran-Ferguson Act, whose grant of authority to the States to regulate and tax insurance is restricted to "[*t*]*he business of insurance*, and every person engaged therein." 15 U.S.C. 1012(a) (emphasis added).

The deemer clause further illuminates the scope of the savings clause. The deemer clause makes specific reference to state laws "purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. 1144(b)(2)(B). As stated in *Metropolitan Life*, 471 U.S. at 741, "[u]nless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans." Accord *FMC Corp.*, 498 U.S. at 64. By parity of reasoning, the savings clause would appear to extend to state laws "purporting to regulate insurance companies" with respect to aspects of their business other than their

insurance contracts, even if the McCarran-Ferguson Act would not exempt those laws from federal preemption. The deemer clause also makes specific reference to "an[y] insurance company *or other insurer*," 29 U.S.C. 1144 (b)(2)(B) (emphasis added), a phrase that encompasses entities in addition to traditional insurance companies. Reading the savings clause in light of this portion of the deemer clause, then, the state laws that "regulate[] insurance," and are therefore saved from preemption, must include those applicable not only to traditional insurance companies, but also to "other insurer[s]."

2. The 11% and 13% surcharge statutes are laws that regulate insurance within the common-sense meaning of that term. The court of appeals mistakenly believed that the surcharges regulate hospital rates and therefore cannot be regarded as regulating insurance. Pet. App. A26-A27. To the contrary, however, both surcharges are "specifically directed" toward the insurance industry for purposes of ERISA's insurance savings clause. See *Pilot Life*, 481 U.S. at 50.

First, the surcharges constitute insurance regulation because the determination whether a payor must pay them turns wholly on the payor's status as a participant in the insurance marketplace, and not on any factor concerning the nature of the hospital, the patient, his or her medical condition, or the medical treatment provided. To be sure, hospital bills provide the mechanism through which the surcharges are collected or distributed.[9] But that fact is insufficient to place the surcharges outside the

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[9] To the extent the 11% surcharge raised revenues for the State, see N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney 1993) (*reproduced at* Pet. App. A104), that fact does not diminish its status as an insurance regulation. Otherwise, a tax on insurance premiums could not be considered insurance regulation. See *General Motors Corp.* v. *California State Bd. of Equalization*, 815 F.2d 1305, 1309-1310 (9th Cir. 1987) (sustaining, under savings clause, tax assessment against insurer but calculated on basis of benefits paid), cert. denied, 485 U.S. 941 (1988).

ERISA savings clause; nothing in ERISA's savings clause "purports to distinguish between traditional and innovative insurance laws." *Metropolitan Life*, 471 U.S. at 741.

In addition, the surcharges serve traditional objectives of insurance law. Their primary function is to reduce the rate advantage enjoyed by commercial insurers and to account for the greater costs the Blues and some HMOs incur as a result of their open-enrollment and community-rating policies.[10] That function is related to traditional objectives of insurance regulation, such as risk spreading,[11] regulating rates,[12] and ensuring the solvency of insurers.[13] It speads the higher risks (which are now concentrated among the Blues) over a larger pool by encouraging a broadening of the Blues' customer base, at the expense of commercial insurers (and certain special-

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[10] Open enrollment means that the insurer will accept as an enrollee any person or group, and dependents, "at all times throughout the year" without regard to age, sex, physical condition, illness, or occupation, and will not terminate the enrollee "due to claims experience." N.Y. Ins. Law §§ 3231(a), 4317(a), 4318 (McKinney Supp. 1994). "[C]ommunity rat[ing]" means that the insurer employs "a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation." *Id.* §§ 3231(a), 4317(a).

[11] See, *e.g.*, *Royal Drug*, 440 U.S. at 211-212 (the "spreading and underwriting of a policyholder's risk" is one "indispensable characteristic of insurance"); *Pireno*, 458 U.S. at 127-128.

[12] See, *e.g.*, *Metropolitan Life*, 471 U.S. at 728 n.2 ("[l]aws regulating aspects of transacting the business of group insurance include, for example, those regulating * * * rates"); *Royal Drug*, 440 U.S. at 224 n.32; *National Sec.*, 393 U.S. at 460 ("[c]ertainly the fixing of rates is part of th[e] [insurance] business").

[13] See, *e.g.*, *Metropolitan Life*, 471 U.S. at 728 n.2; see *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202, 2209-2210 (1993).

ized funds).[14] The surcharges are designed to affect the calculation of insurance rates by reducing the cost differential that existed between the Blues and the other insurers. And by countering the effects of the commercial insurers' practice of selecting lower-risk individuals, the surcharges are intended to maintain the solvency of the Blues by alleviating the financial stress they have experienced as insurer of last resort.

3. The 11% and 13% surcharges also satisfy all three *Pireno* factors in this setting. As discussed above—and as the court of appeals correctly held, see Pet. App. A28—the surcharges satisfy the first factor of "transferring or spreading a policyholder's risk." *Metropolitan Life*, 471 U.S. at 743 (quoting *Pireno*, 458 U.S. at 129).

Contrary to the holding of the court of appeals, Pet. App. A28, the 11% and 13% surcharges also satisfy the second *Pireno* factor, because they regulate "an integral part of the policy relationship between the insurer and the insured." *Metropolitan Life*, 471 U.S. at 743 (quoting *Pireno*, 458 U.S. at 129). The surcharges are premised on the open-enrollment and community-rating policies of the Blues and HMOs—policies that are directly reflected in the formation of insurance contracts—and their purpose is to make hospitalization coverage available to more individuals, at an overall lower price. In addition, the surcharges establish "different payment rates" for different categories of payors, Pet. App. A27, with the specific intent of influencing the rates each category of payor charges.

Finally, the 11% and 13% surcharges satisfy the third *Pireno* factor because they are, in relevant respects, "limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743 (quoting *Pireno*, 458 U.S.

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[14] Indeed, the surcharge statutes are nearly identical in purpose and effect, albeit not method, to the law upheld in *Metropolitan Life* as a risk-shifting insurance regulation. See 471 U.S. at 731, 743.

at 129). The court of appeals held that the third factor is not satisfied because the surcharges "involve entities beyond the insurance industry," such as "the State, hospitals, patients, HMOs, and self-insured funds." Pet. App. A29. But the fact that the surcharges in some sense "involve" patients, hospitals, and the State is of little significance.[15] Insurance regulation generally is intended to have an effect on the customers of insurance companies —in this case, hospital patients—and to carry out the public policies of the State. So long as the amount of the surcharges is determined solely by the nature of the payor —*i.e.*, the payor's role in the insurance industry—the third factor is satisfied, regardless of the fact that hospitals collect both surcharges and retain the proceeds of the 13% surcharge.[16]

The court also erred in holding, as a matter of law, that HMOs are not part of the insurance industry for purposes of ERISA's insurance savings provision. See Pet. App. A26 n.5, A29 n.6. An HMO combines the function of an insurer (since for a set price it assumes the risk that a person will need medical care) and a

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[15] This Court has held that the protections of the McCarran-Ferguson Act should not be denied "*solely* because they involve parties outside the insurance industry." *Pireno*, 458 U.S. at 133. Although "the involvement of such parties * * * constitutes part of the inquiry" under that Act, it is "not dispositive." *Ibid*; see also *Hartford Fire*, 113 S. Ct. at 2902 ("the foreign reinsurers are hardly 'wholly outside the insurance industry'"), quoting *Royal Drug*, 440 U.S. at 231.

[16] Indeed, the New York statutes involve non-insurance entities to a far less degree than did the Ohio creditor priority statute that was found to be protected by the McCarran-Ferguson Act in *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202 (1993). Although the Ohio statute regulated a relationship between policyholders and other competing creditors that had nothing to do with the business of insurance, this Court found the Ohio statute to be "confined entirely to entities within the insurance industry." *Id.* at 2209.

provider of medical care (since it generally either provides the medical care itself or arranges for others to provide the care).[17] See *Royal Drug*, 440 U.S. at 227 n.34, 230 n.37 (recognizing that "certain aspects" of advance-payment medical-benefits plans, such as the contract between the plan and its policyholders, may be the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012). Therefore, insofar as the 11% and 13% surcharges "regulate" HMOs in their role as insurers in the same way that they "regulate" the Blues, *i.e.*, by exempting them from the surcharges, it is entirely appropriate to view the surcharges as an aspect of the regulation of insurers for ERISA preemption purposes.[18]

In any event, the third *Pireno* factor should not be applied rigidly when it is used in analysis under the ERISA savings clause. The third factor was developed to limit the term "business of insurance" in the second clause of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), to entities within the insurance in-

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[17] The court of appeals itself recognized that HMOs provide "insurance" when it stated in a different portion of its opinion that "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans." Pet. App. A6. See p. 18 n.7, *supra*. As the context makes clear, the court was including those who have HMO coverage among those who "have private health care *insurance*" (emphasis added).

[18] Many appellate courts have held that HMOs are insurers for certain purposes. *E.g.*, *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 891-892 (7th Cir. 1994) (ERISA); *In re Estate of Medcare HMO*, 998 F.2d 436, 444-445 (7th Cir. 1993) (Bankruptcy Code); *Stuart Circle Hosp. Corp.* v. *Aetna Health Management*, 995 F.2d 500, 501, 503 (4th Cir.) (ERISA), cert. denied, 114 S. Ct. 579 (1993); *Ocean State Physicians Health Plan, Inc.* v. *Blue Cross & Blue Shield*, 883 F.2d 1101, 1107-1108 (1st Cir. 1989) (McCarran-Ferguson Act), cert. denied, 494 U.S. 1027 (1990); *Klamath-Lake Pharmaceutical Ass'n* v. *Klamath Medical Serv. Bureau*, 701 F.2d 1276, 1287 (9th Cir.) (McCarran-Ferguson Act), cert. denied, 464 U.S. 822 (1983). The Blues are also insurers for those purposes. *Ocean State*, 883 F.2d at 1108.

dustry. An important rationale for that limitation is that the McCarran-Ferguson Act provides an exemption from the federal antitrust laws.[19] Such exemptions are narrowly construed, *Royal Drug*, 440 U.S. at 231, and in the insurance setting a broad construction could create "the potential to restrain competition in noninsurance markets." *Pireno*, 458 U.S. at 133; see also *Royal Drug*, 440 U.S. at 231 ("an exempt entity forfeits antitrust exemption by acting in concert with nonexempt parties"); *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202, 2209-2210 (1993). By contrast, ERISA's insurance savings clause preempts any state law that "regulates insurance," not merely the "business of insurance," and the policy of narrowly construing exemptions from the antitrust laws is inapplicable here.

4. For the foregoing reasons, even if this Court concludes (contrary to our submission in Point A) that application of the 11% and 13% surcharges to commercial insurers and HMOs "relates to" the ERISA plans to which they sell coverage, those surcharges are preserved from preemption by the insurance savings clause.

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[19] Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), provides:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That * * * [the federal antitrust statutes] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

The second clause is the portion following the word "*Provided*."

CONCLUSION

The judgment of the Second Circuit should be reversed.[20]

Respectfully submitted.

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NOVEMBER 1994

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[20] As stated in note 3, *supra*, the case should be remanded to afford the court of appeals (or the district court) an opportunity to address, in the first instance, whether the question of the application of the 13% surcharge to self-insured ERISA plans is presented in this case; and, if so, whether the 13% surcharge "relates to" self-insured ERISA plans. If the 13% surcharge is found to so relate, the court below would have the opportunity to address as well the application of the savings and deemer clauses to those plans.

APPENDIX

1. Section 514(a) of ERISA, 29 U.S.C. 1144(a), provides in full:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

2. Section 514(b)(2) of ERISA, 29 U.S.C. 1144(b)(2), provides in full:

> (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(11) (12) (12)

Nos. 93-1408, 93-1414 and 93-1415

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In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
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v.
TRAVELERS INSURANCE CO., *et al.*
Respondents.

MARIO CUOMO, *et al.*,
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v.
TRAVELERS INSURANCE CO., *et al.*
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HOSPITAL ASSOCIATION OF NEW YORK,
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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF THE AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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BRIEF OF THE AMERICAN FEDERATION OF STATE COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

This brief *amicus curiae* of the American Federation of State County and Municipal Employees, AFL-CIO

("AFSCME") is filed with the written consent of the parties, as provided for in the Rules of this Court.

INTEREST OF THE *AMICUS CURIAE*

AFSCME is a nationwide labor organization with a current membership of approximately 1.3 million public employees. Several thousand AFSCME members are employed by public hospitals in the State of New York and are thus interested in the validity of the state statutes at issue here, which govern the cost of inpatient hospital services.

AFSCME's brief is joined by two AFSCME affiliates: New York City District Council 37, AFSCME, AFL-CIO ("District Council 37"); and State of New York, Civil Service Employees' Association, Local 1000, AFSCME, AFL-CIO ("CSEA"). District Council 37 represents New York City hospital employees, and CSEA represents New York State hospital employees.

INTRODUCTION AND SUMMARY OF ARGUMENT

The state scheme of regulating charges for hospital care that is at issue in this case is crafted to address both the obligations placed on hospitals to care for segments of the population at charges that are below what an unregulated market would generate and the complications inherent in providing inpatient hospital care insurance coverage to high risk individuals and groups. The essence of the solution adopted by the State is a system of differential hospital prices—and of differential government surcharges to those regulated prices—that is designed to spread the costs of providing inpatient hospital care to all segments of the population uniformly among private third-party payors, rather than to permit those costs to fall disproportionately on some payors because of the particular characteristics of the segment of the population that those payors serve.

A group health plan must necessarily choose from among various options for paying for health benefits pro-

vided to those covered by the plan. The decision below stands for the proposition that any state scheme for regulating hospital charges for inpatient care that alters the relative costs of those various options from what those costs would have been in an unregulated market "relate[s] to" health plans covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*, and hence is preempted by ERISA § 514(a). On that decision, then, ERISA preemption serves to assure that ERISA plans can secure inpatient hospital services through a "free market" that is not "distorted" by state regulation of hospital charges.

It is our submission that ERISA does not force a state to choose a segmented "free market" hospital cost payment structure with its discriminatory inequities over a market structure that takes the benefit out of opportunistic activity by charging all private payors their fair portion of total hospital costs. ERISA, we submit, was not founded on the premise that health care providers and health insurers with whom plan sponsors and fiduciaries deal must be unregulated and that the providers and insurers must be free to set their charges and otherwise conduct their affairs so as to maximize the market options of ERISA health plans. ERISA does not in fact assume, dictate, regulate, or prefer any given means of providing, pricing, or insuring health care.

Contrary to the ruling below, then, ERISA cannot be read to deprive a state of the authority—which the States otherwise have as part of their traditional police powers—to regulate health care providers and insurers and to thereby structure the markets in which those entities function in the manner that the state determines will best achieve legitimate state regulatory objectives—and that does not interfere with any objective of ERISA.

As we show below, the general language of ERISA's preemption provision § 514(a), 29 U.S.C. § 1144(a), does not warrant such a federal intrusion into the tradi-

tional prerogatives of the States. The words "relate to any employee benefit plan" in § 514(a) were not intended to preempt state regulation that simply alters the relative costs of options that plan sponsors and fiduciaries remain free to adopt. This Court's decisions on the meaning of § 514(a) are entirely consistent with that understanding.

ARGUMENT

I

The state statutory provisions here at issue are part of a comprehensive scheme of regulation. We therefore begin by setting out the essentials of that scheme and the place of the challenged provisions within that scheme.

(a) The public policy of the State of New York, and of the United States, is to ensure that all segments of the population will be able to secure needed inpatient hospital care. Both the State and the Federal Government therefore treat hospitals as institutions imbued with a public purpose and subject both to certain responsibilities and to certain forms of price regulation. The Medicare and Medicaid programs finance hospital care—albeit on a severely discounted price basis established by government regulation—for a large part of the elderly population and the indigent population. Under certain circumstances, hospitals are, moreover, required to provide care to indigent patients not covered by Medicaid without receiving any payment of the costs associated with providing that care.

In addition, the practice of individuals in this society is to safeguard against the uncertainties and high costs associated with serious illness and accidents by securing insurance to provide for the costs of inpatient hospital care. There is a wide variation in the general population, from individual to individual, and among certain groupings of individuals, as to the risks of incurring significant inpatient hospital costs. If individuals and insurers were left to their own devices, individuals and groups with low risk characteristics would be able to secure hospitalization insurance at comparatively low premiums. And,

those with high risk characteristics would either be unable to secure such insurance or would be forced to pay higher premiums for that insurance.

(b) In New York, Blue Cross and Blue Shield ("the Blues"), both by practice and by virtue of regulatory obligation, have historically accepted the public burden of providing health insurance to otherwise uninsurable, high risk populations. *See* Joint Appendix ("JA") 161-62, 196-98, 218-19. The Blues have carried that burden through such practices as open enrollment and community rating of small, high risk groups. *Id.*

Since 1970, the State, pursuant to statute, has set the prices charged by hospitals to the Blues for inpatient hospital services at levels below those charged to other third-party payors. JA 148, 222. The State's action provided what was in practical terms a subsidy that enabled the Blues to continue to cover otherwise uninsurable, high risk populations and to provide insurance to other populations at competitive rates. This action meant that hospitals charged higher prices to other third-party payors to cover the costs of the services provided to the Blues' insureds—as well as of the services provided to Medicaid and Medicare patients at discounted rates. JA 148-49, 162.

(c) In the 1970s and early 1980s, some third-party payors were able to use their market power to obtain discounted hospital prices at or approaching the prices charged to the Blues. JA 149-50. This resulted in still more cost-shifting to the remaining third-party payors. JA 150. By 1982, the prices charged to all private third-party payors other than the Blues were on average 25% higher than the prices charged to the Blues, and in some areas of the State as much as 40% higher. JA 149.

In 1983, the State implemented a new statute setting a maximum rate differential between the Blues and other private third-party payors (except Health Maintenance Organizations, "HMOs") at 15%, and prohibiting hospitals from charging discounted prices to preferred private

third-party payors and not to all such payors. The practical result of this regime was a generally uniform 15% differential between the Blues and the other private third-party payors. JA 150.

(d) In 1988, New York replaced the 1983 scheme with a new comprehensive scheme, directly regulating the hospital charges for inpatient services to all third-party payors. The scheme establishes a base level price for every inpatient hospital procedure. Appendix to Petition for Writ of Certiorari ("Pet. App") 101-02. That is the price paid to the hospitals by Medicaid, the Blues, and HMOs. Pet. App. 101. By 1988, HMOs were in the same position as the Blues by reason of state regulation requiring similar open enrollment and community rating practices. JA 261-64.

The 1988 scheme establishes a second category of payors, including all commercial insurance companies and all self-insured groups that directly pay hospitals for inpatient hospital services provided to their beneficiaries. Prices for payors in this category are set at 13% above the base level. Pet. App. 102. This differential in the amounts payable to hospitals is a continuation of the State's effort to spread the costs of providing hospital care to high risk populations among the entire class of private third-party payors, and not just among those payors that have assumed the burden of providing that coverage. JA 153, 164-65, 228-29, 263-64.

In sum, with respect to the Blues and to HMOs, the 13% pricing differential serves to compensate for the competitive disadvantage those entities incur by virtue of their disproportionate coverage of high risk populations.

(e) In 1992, the State enacted additional provisions directed toward protecting the inpatient hospital services market. The State was confronted with a growing practice by commercial insurers that was causing further skewing of pricing in the health insurance market, and was again jeopardizing the ability of the Blues and HMOs to compete in that market. The problem, in brief,

was that, particularly in the late 1980s and early 1990s, private commercial insurers were actively "cherry picking" low risk groups, by offering those groups low premiums based on experience rating, thereby leaving the Blues, and the HMOs, the segment of the population that was becoming even more disproportionately comprised of high risk individuals. *See* JA 204-06, 232-33.

The State addressed this problem in two stages. The initial stage was to put into place a now-expired one-year surcharge of 11% on all inpatient hospital charges to patients covered by commercial insurers, but not to patients covered by other payors. Pet. App. 104. This surcharge served as a short-term measure to correct the market distortions resulting from commercial insurers experience-rating small low risk groups in order to garner the most attractive segments of the population. JA 206-07, 232-34.[1]

A long-term measure designed to address the "cherry picking" problem was put into effect by the State immediately upon the expiration of the one-year surcharge—April 1, 1993. This enactment requires that all health insurance policies in the State for individuals or for groups of 50 or fewer persons be issued on a community rated and open-enrollment basis, whether offered by commercial insurers or by the Blues. *See* N.Y. Ins. Law § 4317 (a) (McKinney Supp. 1994); JA 294.

A second aspect of the 1992 market reforms addressed the State's desire to control the spiraling costs of the Medicaid program by inducing HMOs—which utilize cost-saving managed-care techniques—to enroll an increased share of the Medicaid population. JA 175-77. The State sought to accomplish this purpose by imposing a variable surcharge on inpatient hospital services charged to HMOs, varying from 9% down to zero, depending upon each HMO's success in enrolling a defined target

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[1] Unlike the 13% pricing differential, this surcharge was paid to the State and thus served the additional purpose of providing revenue for the State. JA 284-85.

number of Medicaid eligible persons. Pet. App. 106-13; JA 175-77.[2]

II

Among those that provide group coverage for inpatient hospital costs and that arrange for the payment of such costs on behalf of members of the group are single employer, multi-employer, and employee organization health benefit plans that come within the ambit of ERISA. ERISA defines the term "employee welfare benefit plan" to include any plan established by an employer or employee organization "for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). The New York regulatory scheme here at issue has an impact on ERISA health benefit plans and that impact is what generates this ERISA preemption dispute. We therefore pause to describe that impact in some detail.

To begin, the state scheme does *not* regulate ERISA health benefit plans. The provisions at issue here do *not* impose any legal requirement on the sponsors or fiduciaries of such ERISA plans to take, or not to take, any particular actions. The impact of the scheme on ERISA plans—and the only impact—is not regulatory but economic. ERISA plans, like other third-party payors, are subject to the secondary effects of the state regulation of hospital charges. By reason of that regulation of entities that are not immune from state regulation under ERISA or any other federal law, ERISA plans face a different set of economic possibilities and opportunities than the plans would face in an unregulated market or a differently regulated market.

After the state regulation at issue here, as before, ERISA health plans continue to be free to choose from

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[2] This surcharge is also paid to the State and not to the hospitals. JA 175.

among a variety of health benefit packages for the plans' beneficiaries, and a variety of methods for providing those benefits. For example, in New York as elsewhere, the plans are entirely free to purchase health insurance from non-profit or for-profit insurance carriers; contract with health maintenance organizations or preferred provider groups; enter into arrangements that include some combination of the foregoing arrangements; or pay for the covered health services directly rather than through some intermediary. Pet. App. 6-7.

By definition, government regulation of a class of service providers aimed at restructuring their market will serve to alter the relative cost-based advantages of the providers. Here, because of the scheme at issue, certain mechanisms for paying for inpatient hospital services provided to ERISA plan beneficiaries may well have become more or less attractive than in a market that had not been restructured. Thus, absent the restructuring, the Blues might not have been able to offer to ERISA plans a package as advantageous to the plans as can be offered by the Blues after the restructuring. By the same token, other mechanisms for paying for inpatient hospital services—commercial insurance or self-funding—may have become relatively less advantageous from the plans' standpoint, at least on a cost basis.

These changes in the relative advantages of the various payment mechanisms are the direct consequence of the State's restructuring the market so that all private payors equitably share the costs of providing inpatient hospital care to all segments of the State's population, including the high risk and indigent populations, rather than permitting those costs to fall disproportionately on some payors because of the particular characteristics of the segment of the population that they serve.

By reason of these market adjustments, those payors that cover a disproportionately high proportion of low risk segments of the population will have to pay more for inpatient hospital services than the amount that they

would have paid in a market predicated on the risk characteristics of each particular segment of the population and on the actual costs of the hospital care provided to each covered individual. And, of course, the opposite would be true for those payors that cover a disproportionately high proportion of high risk segments of the population.

III

There is room to dispute the wisdom and the efficacy of the State's efforts to regulate hospital charges to prevent the inpatient hospital services market and the health insurance market from becoming segmented and to provide that the moneys paid by all insured patients cover the shortfall caused by discounts to Medicare and Medicaid and by the provision of services to indigent patients not covered by Medicaid.

But there is no room to dispute that the State is, indeed, regulating hospital charges and that the entirety of the effect on ERISA health benefit plans is the *economic* effect of this regulation. The question here then is whether ERISA precludes a state from engaging in such regulation of hospital charges—or, more technically, whether ERISA exempts ERISA health plans from having to pay for patient care provided to their beneficiaries on a basis that charges them their share of total hospital costs as established through such a regulated market.

(a) ERISA § 514(a)—the ERISA preemption provision—states that "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has made it plain that, as the statutory language indicates, ERISA preemption is broad. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) ("A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."). But neither

the statutory words nor this Court's decisions interpreting those words stand for the proposition that ERISA preemption is limitless. The term "a law that 'relate[s] to' a party" is not a term of art that is inevitably equated with, or inevitably encompasses, every "state regulation of a third person that has an economic effect on that party." And, it is our position here that a state law regulating hospital charges, and doing so on a rational basis that does not single out ERISA plans, is *not* a state law that "relate[s] to" ERISA plans merely because the law generates secondary economic effects on all private payors including ERISA plans.

On a certain world view everything is related to everything else. Whatever the merit of that view, if the "relate to" language of § 514(a) were read in that way, ERISA plans would literally be placed above all the civil law of the states in which they operate. Such a reading would be extraordinary. We know of no context in which Congress has ever taken such a step with respect to any private entity. To ascribe such an intention to Congress from the general words "relate to," and without a more specific and express statement of such an intention, would run counter to the most basic understandings of the relationship between the Federal Government and the States. "[W]e start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Hillsborough County v. Automated Medical Labs., Inc.* 471 U.S. 707, 715 (1985) (internal quotations omitted). *Accord, e.g., Cipollone v. Liggett Group, Inc.*, —— U.S. ——, 112 S. Ct. 2608, 2617-18 (1992).

That being so, this Court has already made it clear that "relate to" in § 514(a) does not sweep away the run of state law. In *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), this Court recognized that § 514(a) does not preempt a variety of state law claims brought directly against ERISA plans:

> ERISA plans may be sued in a second type of civil action, as well. These cases—lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan—are relatively commonplace. Petitioners and the United States (appearing here as *amicus curiae*) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA § 514(a). [*Id.* at 833 (footnote omitted).]

The state law actions described as not "relate[d] to" ERISA plans in this passage operate directly on such plans. Those actions are predicated on legal obligations imposed on the plans by state law, and may result in the imposition on the plans of state law remedies. The state scheme at issue here has *no* such relational nexus to ERISA plans. As we have shown the state scheme regulates hospital prices and imposes surcharges on commercial insurers and HMOs. The sum and substance of the state regulations' relation to ERISA plans is to restructure the market in which ERISA plans, among others, deal in a manner that has an economic impact on those plans; that impact is one that alters the relative costs of the various options that are available to ERISA plans for paying for the health benefits of plan beneficiaries from what those costs would have been in an unregulated market. And, this economic consequence of the state scheme affects ERISA health plans in precisely the same way as non-ERISA health plans.

So far as we are aware, in the "normal sense of the phrase," *Shaw*, 463 U.S. at 97, a law regulating A in a manner that structures what A can offer on the market and thereby affecting B, C and D who are on the other side of that market is not a law that "relate[s] to" B, C and D. In our jurisprudence, B, C and D have no expectation, much less a right, to participate in any particular market or to deal with market participants who are free of regulatory constraints. That general understanding applies with full force to a market structured by health care regulations.

Health care providers have long been heavily regulated by the States. State licensing provisions, tax provisions, staffing requirements, patient care protocols, malpractice standards and remedies, health care subsidies and scores of other forms of state regulation are major determinants of the types of inpatient hospital care that is available on the market in any state and of the cost of that care. The scheme of regulation here at issue is well within the scope of the traditional state regulation of health care. As we have shown, the State has sought, through regulation of hospital charges, to spread the costs of providing inpatient hospital care to all segments of the population uniformly among the various types of private third-party payors. Like the other forms of state regulation of the provision of hospital care, the regulation of hospital charges here is a classic exercise of the police power to achieve a basic social good. *See, e.g., Pennell v. City of San Jose*, 485 U.S. 1, 11-14 (1988); *Fisher v. City of Berkeley*, 475 U.S. 260, 264 (1986); *Nebbia v. New York*, 291 U.S. 502 (1934); *Munn v. Illinois*, 94 U.S. 113 (1877).

State regulation of hospital care—and the attendant effects of that regulation on the costs of hospital care—was prevalent when ERISA was enacted, as it is today. Yet there is nothing in ERISA's language or its legislative history evincing an affirmative congressional intent to federalize the regulation of the provision of hospital care in all its manifest complexity. Nor is there any express indication in ERISA of a congressional intent to end state regulation of hospital care and to replace it with a federally mandated regulatory void—or, in more precise terms, to entitle ERISA plans to secure hospital services in an unregulated market.

The only possible exception to the foregoing assertions is the "relate to" language of § 514(a), standing alone. We submit that those words cannot possibly bear that weight. It is one thing to say, as this Court has said, that in the interests of uniformity Congress intended to prevent the States from directly or indirectly imposing

legal or administrative obligations on ERISA plans. *See infra* pp. 14-18. That, after all, is consistent with the Act's purpose in setting a national legal framework for employee benefit plans, including plans that operate on a multi-state basis. It is quite another to say that Congress, without a whisper to so indicate, intended to oust the States from regulating health care providers in any manner that affects—or substantially affects—the opportunities of ERISA plans. That would amount to a congressional intention to create a right of ERISA plans to procure hospital services for plan beneficiaries in a uniform unregulated market. It would be folly to attribute to Congress the silent desire to create a nationwide health care "free market" for ERISA plans. There has never been such a market and it is all but impossible to conceptualize how such a market could be created in this society or how it could function.

Even without the kinds of state law provisions at issue here, the markets for procuring health services available to ERISA health plans will differ from state to state depending upon a multitude of variables respecting the structure of health care delivery systems within each state, demographic and geographic considerations, variations in cost structure in the health care delivery systems and in the insurance systems within each state, and so on. Multi-state ERISA health plans must take these market differences from state to state into account in determining what kind of payment system to adopt or maintain. The provisions at issue here do no more than affect the relative cost structure in one of the markets ERISA plan sponsors and fiduciaries must evaluate in exercising their discretion to adopt a payment system suited to their respective plans.

(b) While the precise issue presented here is one of first impression, this Court's cases construing the meaning of "relate to" in § 514(a) are entirely consistent with the conclusion that the state statutes at issue here are not preempted by ERISA. This Court's decisions giving that language a broad sweep have been generated by

state laws that were premised on the existence of ERISA plans or that sought, directly or indirectly, to impose a *legal requirement* on ERISA plans—*viz.*, that sought to require those plans to take, or not to take, a certain action. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (provision in New Jersey workers' compensation statute "relates to" ERISA pension plans because it would prohibit plans from employing "one method for calculating pension benefits—integration—that is permitted by federal law"); *Shaw*, 463 U.S. at 97 ("the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans"); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (Massachusetts insurance law provision "bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy."); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) (state common law tort and contract actions "relate to" ERISA plans to the extent that they are premised on the failure of an ERISA plan to pay benefits); *Mackey*, 486 U.S. at 829 ("The Georgia statute at issue here expressly refers to—indeed, solely applies to—ERISA employee benefit plans."); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (Pennsylvania antisubrogation law relates to ERISA plans because it "prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party."); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) ("Texas cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan."); *District of Columbia v. Greater Washington Bd. of Trade*, —— U.S. ——, 113 S. Ct. 580, 583 (1992) (provision in workers' compensation statute "relate[s] to" ERISA plans where the obligations it imposes on employers depends entirely on whether the employer has chosen to create and maintain an ERISA plan).

In *Shaw*, the Court quoted liberally from floor statements made by three members of Congress who managed the legislation. Those floor statements describe the final, conference version of § 514(a) as preempting state laws that, directly or indirectly, *impose legal requirements* for the operation of ERISA plans.

For example, Representative Dent, in the passage quoted in *Shaw*, stressed that the conference version of § 514(a) was intended to assure "the reservation to Federal authority [of] sole power to *regulate* the field of employee benefit plans . . . by eliminating the threat of conflicting and inconsistent State and local *regulation*." 463 U.S. at 99, quoting 120 Cong. Rec. 29,197 (1974) (emphasis supplied). Similarly, Senator Williams referred to an intention "to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local *regulation*." *Id.*, quoting 120 Cong. Rec. at 29,933 (1974) (emphasis supplied). And, Senator Javits said that § 514(a) addresses "the desirability of further *regulation*—at either the State or Federal level." *Id.* at 99 n.20, quoting 120 Cong. Rec. 29,942 (1974) (emphasis supplied). *See also* Senator Javits' comment, in a colloquy not quoted in *Shaw*, that with respect to plans providing prepaid legal services "it is intended that State regulation—but not bar association ethical rules, guidelines or disciplinary actions" be preempted, Legislative History of ERISA, 4789 (Sen. Labor Sub. Print 1976); *id.* ("the State, directly or indirectly through the bar, is preempted from regulating the form and content of a legal service plan").

Subsequently, in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987), the Court characterized these floor statements as "clearly disclos[ing] the problem that the preemption provision was intended to address":

> These statements reflect recognition of the administrative realities of employee benefit plans. . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such

> a system is difficult to achieve, however, if a benefit plan is subject to different *regulatory requirements* in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others. . . .
>
> ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation. . . . *Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.* [482 U.S. at 9-11 (emphasis supplied).]

See also id. at 10-11 (reviewing the earlier cases in which ERISA preemption was found, and concluding that "[w]e have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's *administrative scheme* would be subject to conflicting *requirements*") (emphasis supplied).

Consistent with these legislative materials, this Court in *Ingersoll-Rand* stated the rationale for ERISA pre-emption as follows:

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government [498 U.S. at 142.]

That rationale for preemption defines the outer limits of the "relate to" concept in § 514(a). State laws that impose no "requirements," directly or indirectly, on ERISA plans are outside those limits. By definition such state laws cannot impose requirements contrary to the

requirements of ERISA or threaten ERISA plans with the possibility of being subject to different or conflicting requirements in other states.[3]

CONCLUSION

For the foregoing reasons, the decision and judgment of the United States Court of Appeals for the Second Circuit in this case should be reversed.

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[3] If, contrary to what we have argued, New York's statutory scheme is found to "relate to" ERISA plans within the meaning of ERISA § 514(a), the Court would then have to consider the second question presented. That question is whether the New York statutory scheme is saved from ERISA preemption by ERISA § 514(b)(2)(A), which provides, in pertinent part, that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*." 29 U.S.C. § 1144(b)(2)(A) (emphasis supplied). Given the substance and the purpose of the New York statutory scheme at issue here, *see supra* pp. 4-8, it is our submission that the New York scheme is one that "regulates insurance" within the plain "common sense" meaning of that term. *See Metropolitan Life*, 471 U.S. at 740; *Pilot Life*, 481 U.S. at 48. We thus fully embrace the position of petitioners and the United States on this issue.

(12) (13) (13)

Nos. 93-1408, 93-1414, 93-1415

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In The

Supreme Court of the United States

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation Of Caption See Reverse Side Of Cover)

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF FOR THE STATES OF MINNESOTA, CONNECTICUT, MARYLAND, ILLINOIS, INDIANA, MASSACHUSETTS, MISSOURI, MONTANA, PENNSYLVANIA, TEXAS, WEST VIRGINIA AND WYOMING AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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HOSPITAL ASSOCIATION OF NEW YORK STATE,

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STATEMENT OF INTEREST

The amici curiae states, through their attorneys general, respectfully submit this brief in support of Petitioners. Amici support reversal of the decision of the Second Circuit Court of Appeals holding that New York's hospital rate surcharges are preempted by ERISA.

The amici states have a strong interest in the ERISA preemption issues presented by this case. The states have an interest in assuring that the scope of ERISA preemption is maintained within the ambit of congressional purpose and that the states' remaining sphere of regulatory power is not improperly undermined. Although the language of the ERISA preemption provision is broad, Congress did not intend to preclude all state regulation that indirectly has an economic effect on ERISA plans, as the Second Circuit has held.

On a more specific level, the amici states have a critical interest in this case because the Second Circuit's ruling significantly impinges on their ability to implement legislative solutions in an area of traditional state power, the regulation of health care. States have played a long-standing role in both the overall regulation of the health care system and the provision of health care to the indigent. The extensive public debate on health care of the past two years has made well-known the enormous and challenging tasks of containing skyrocketing costs and at the same time providing adequate, quality care to all those in need.

The states cannot afford to leave these issues unaddressed. As pointed out by the GAO:

> State governments have a major stake in financing and providing health care. States are concerned about the growing proportion of their

> budgets devoted to health – they already spend an average of 20 percent of their total budgets on health-related programs. Yet in some states, almost one-quarter of the population is uninsured.

Human Resources Div., U.S. General Accounting Office, *Access to Health Care, States Respond to Growing Crisis* 2 (June 1992).

It is widely recognized that ERISA preemption serves as a major obstacle to many of the reforms that states would like to enact to address these pressing issues of health care cost containment and the expansion of access to health care. *See, e.g., id.;* Patricia A. Butler, National Governors Ass'n, *Roadblock to Reform, ERISA Implications for State Health Care Initiatives* (1994); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured,* 24 U.C. Davis L. Rev. 255 (1990); Vicki Gottlich, *ERISA Preemption: A Stumbling Block to State Health Care Reform,* Clearinghouse Review 1469 (March 1993).

The Second Circuit's adoption of an indirect economic impact basis for ERISA preemption is thus of great concern to the amici states because it is a significant expansion of already broad ERISA preemption. The approach to ERISA preemption embraced in this case and its progeny threatens effectively to block appropriate state regulation in the health care area. ERISA preemption has in the past been referred to as a quicksand. *Jordan v. Reliable Life Ins. Co.,* 694 F. Supp. 822, 827 (N.D. Ala. 1988). The amici states fear that unless the decision below is reversed, the application of the indirect economic impact standard will necessarily intensify the force of ERISA preemption, and the states will be faced not with a quicksand, but with an inescapable black hole.

SUMMARY OF ARGUMENT

The Second Circuit Court of Appeals erroneously concluded that the indirect economic effect of state statutes on ERISA plans, in and of itself, is sufficient to preempt operation of state statutes, in this case surcharges on amounts charged for hospital services. This simplistic test is contrary to Congress' intent in enacting the ERISA preemption provisions. Consistent with the Commerce Clause authority under which ERISA itself was enacted, the core purpose of ERISA preemption is to enable ERISA plans to operate on a multi-state basis, without interference by a patchwork of differing state regulation. Congress did not intend for ERISA to preempt traditional areas of state concern, such as hospital rate-setting and regulation of health care, where they have no impact on interstate operation of ERISA plans. Federal law enacted subsequent to ERISA specifically approves of states establishing their own hospital reimbursement systems and authorizes the establishment of health care-related taxes by the states to generate income that will then be redistributed back to the hospitals. The Second Circuit's expansive approach to ERISA preemption threatens the very measures enacted by states pursuant to these congressional authorizations.

The Court should reject the narrowly-focused economic impact standard of Travelers in favor of an inquiry that includes the factors this Court has employed. This analysis should examine whether the state law singles out ERISA plans for different treatment and whether the state law dictates the manner in which ERISA plans structure themselves or conduct their business, all factors that bear on the recognized core purpose of ERISA preemption.

The states are in serious jeopardy of being forced to abdicate responsibilities and powers to regulate health care if the *Travelers* standard is upheld. With health care

reform now squarely up to the states, it is critical that states have flexibility to establish new programs to spread the burden of uncompensated care experienced by hospitals and to improve access to health care for uninsured individuals.

Many states rely on congressionally-approved health care-related taxes to reimburse hospitals for the uncompensated care they provide to low-income patients and to take advantage of millions of dollars of matching federal revenue available through the Medicaid program. Under *Travelers*, however, these state taxes are in danger of being preempted.

The quality of health care is also at risk if *Travelers* is upheld. State laws that ensure proper sanitary conditions and adequate patient/nurse ratios in hospitals may increase hospital charges to patients. Even these laws, therefore, may be invalidated under the indirect economic impact test in *Travelers*.

The Second Circuit's indirect economic impact standard is a significant expansion of an already broad preemption provision. Congressional intent and principles of federalism that govern preemption analysis require that this expansion be rejected.

ARGUMENT

I. THE SECOND CIRCUIT'S INDIRECT ECONOMIC IMPACT STANDARD FOR ERISA PREEMPTION SHOULD BE REJECTED IN FAVOR OF A MORE BALANCED TEST THAT BETTER REFLECTS THE PURPOSE OF ERISA PREEMPTION.

A. The Indirect Economic Impact Standard Is Contrary To The Purpose Of ERISA Preemption Intended By Congress.

In the decision below, *The Travelers Insurance Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1994) ("*Travelers*"), the Second

Circuit held that mere indirect economic impact alone, such as that which results from the purchase of goods or services by an ERISA plan, is enough to trigger ERISA preemption of state laws. It is this central holding that is of primary concern to the amici states and to which this amicus brief is addressed.

In *Travelers*, three state-imposed surcharges on hospital rates were challenged by plaintiffs consisting of commercial health insurers and a trade association of such insurers. The Second Circuit held that the surcharges are preempted under ERISA because they "force the ERISA plans to either increase plan costs or reduce plan benefits." *Travelers*, 14 F.3d at 720-21 (footnote omitted). The court reasoned that because the surcharges imposed a significant economic burden on commercial insurers and HMOs, "[t]hey therefore ha[d] an impermissible impact on ERISA plan structure and administration." *Id.*

Thus, the court ruled that any state regulation that significantly increases the costs incurred by an ERISA health benefit plan, whether directly or indirectly, is preempted. No inquiry is necessary under the Second Circuit's standard to determine whether or how the structure or administration of the ERISA plan will be affected, because an impermissible effect is presumed from the the economic impact itself. No inquiry is necessary into the effect on the multi-state operation of the plan. Increased cost to the plan is enough.

This indirect economic impact standard for ERISA preemption embraces an analysis that permits state law to be preempted based on a superficial finding of connection with ERISA plans. The approach is flawed because it fails to consider the real purpose for which Congress enacted the ERISA preemption provision and ignores the fact that some of the very regulations that are being

invalidated have been authorized and encouraged by Congress in other statutes.

1. The purpose of ERISA preemption was to facilitate operation of multi-state ERISA plans, not to exempt them from ordinary costs of doing business.

The Second Circuit's indirect economic impact standard bears no relationship to the purpose of the ERISA preemption provision repeatedly identified by this Court. Congress did not intend to create a charmed existence for ERISA plans that would exempt them from any state regulation that increases the cost of goods and services they purchase. Rather, the ERISA preemption provision was meant to preserve the ability of ERISA plans to function on a multi-state basis. As the Court recently explained:

> Section 514(a) [the ERISA preemption provision] was intended to ensure that plans and plan sponsors would be subject to a *uniform body of benefit law;* the goal was to minimize the administrative and financial burden of complying with *conflicting directives* among States or between States and the Federal Government.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990) (citations omitted; emphasis added). Clearly, the core congressional purpose was to avoid a patchwork of differing state regulation that would interfere with efficient multi-state administration of ERISA benefit plans. This concern for the ability of multi-state ERISA plans to operate free of conflicting state regulation is consistent with the Commerce Clause authority under which ERISA was enacted. Preemption based on indirect economic impact does not further that purpose.

Given this repeatedly-acknowledged goal of ERISA preemption, the proper inquiry is whether the challenged

state regulation will interfere with the goal of uniformity. In upholding a Maine statute against an ERISA preemption challenge, the Court used precisely that analysis:

> The Maine statute therefore creates no impediment to an employer's adoption of a uniform benefit administration scheme. Neither the possibility of a one-time payment in the future, nor the act of making such a payment, in any way creates the potential for the type of conflicting regulation of benefit plans that ERISA preemption was intended to prevent. As a result, pre-emption of the Maine law would not serve the purpose for which ERISA's preemption provision was enacted.

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 14-15 (1987) (footnote omitted).[1] The Second Circuit ignores this crucial inquiry about the potential for conflicting regulation and substitutes a simplistic test of increased cost that has no basis in congressional intent.

2. The *Travelers* indirect economic impact standard threatens hospital rate-setting and other state health care measures that Congress specifically authorized.

Congress, as evidenced in the Medicare and Medicaid programs, contemplated the existence of state health

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[1] Although ERISA preemption was intended to prevent conflicting state regulation of ERISA plans, the purpose was not to require uniformity in the sense that all hospital payment rates must be the same in every state. They were not when ERISA was enacted, and they are not now. For example, charges per case in 1974 varied from $494 in Wyoming to $1356 in New York. American Hospital Association, *Hospital Statistics* (1975 ed.). Similarly, in 1992, charges per case ranged from $3807 in Mississippi to $8218 in the District of Columbia. American Hospital Association, *Hospital Statistics* (1993-94 ed.).

care regulation, both to contain hospital costs and to ensure access to health care for low-income people. Another indication that the Second Circuit has carried ERISA preemption beyond the bounds Congress intended is that these state measures, specifically envisioned by federal law enacted subsequent to ERISA, cannot survive the *Travelers* indirect economic impact standard.[2]

The federal Medicare statute, 42 U.S.C. § 1395ww(c)(1), enacted in 1983, expressly gives the Secretary of the United States Department of Health and Human Services ("Secretary") discretion to reimburse hospitals "in accordance with a hospital reimbursement control system in a State" – a provision specifically designed to encourage states to enact cost containment measures in the field of hospital care. One of the conditions a state system must meet is that the state-established rates must be applicable to at least 75% of all revenues or expenses in the particular state for inpatient hospital services. 42 U.S.C. § 1395ww(c)(1)(A). Thus, the general authority given states to establish hospital cost containment systems is inconsistent with a broad-based ERISA exclusion. Indeed, if charges to ERISA plans or their insurers are excluded from hospital rate-setting, it is difficult to see how the 75% minimum target could be achieved.

Another condition for an all-payor state hospital rate system to qualify for Medicare reimbursement is that the state must provide "satisfactory assurances as to the *equitable treatment* under the system of all entities (including

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[2] The district court *Travelers* decision acknowledged that its ruling would mean the demise of states' efforts to regulate and control hospital costs. *See Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996, 1006 (S.D.N.Y. 1993).

federal and state programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients." 42 U.S.C. § 1395ww(c)(1)(B) (emphasis added). It is not reasonable to believe that Congress would have required equity among all payors of hospital charges in the Medicare law, while simultaneously intending to insulate ERISA plans from the reach of hospital rate-setting.

Finally, under provisions enacted in 1983 and most recently amended in 1990, Congress has waived standard Medicare principles of reimbursement in favor of a state's reimbursement system, provided the state system meets a performance test and also provided that not only Medicare, but all third party payors, reimburse hospitals in the particular state on the basis of that state's system.[3] 42 U.S.C. § 1395f(b). Nothing in this legislation even remotely suggests that the term "payors" was intended to exclude ERISA plans.

Therefore, states that engage in hospital rate-setting consistent with authority conferred by federal law are effectuating the intent of Congress. Congress clearly did not intend an ERISA preemption standard of indirect economic impact that strikes down those same rate-setting systems. As Judge Van Graafeiland commented in *Rebaldo v. Cuomo*, 749 F.2d 133, 140 (2d. Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985): "When Congress gives authority with one hand, it ordinarily does not take it away with the other hand."

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[3] Maryland is one state with a genuinely "all-payor" system. All payors pay hospitals on the basis of the state's system. Maryland has retained its Medicare waiver since 1977 without interruption. Other states that have been granted waivers in the past have included Massachusetts, New Jersey, and New York, although these waivers are no longer in effect.

Similarly, federal Medicaid law specifically authorizes states to impose health care-related taxes that are jeopardized by the expanded scope of ERISA preemption adopted in *Travelers*. As part of its 1991 amendments to the federal Medicaid Act, Congress explicitly authorized states to use taxes of general applicability, such as a sales tax extended to hospital charges, 42 U.S.C. § 1396a(t), and health care provider taxes, 42 U.S.C. § 1396b(w), as a means of raising revenue that qualifies for federal matching funds, and which can be redistributed to hospitals to reimburse them for care they provide to low-income patients. 42 U.S.C. §§ 1396(a)(13), 1396r-4.

Like the Medicare hospital rate-setting authorization, Medicaid authorization of these taxes, which requires that they be broad-based and uniform, is directly inconsistent with an economic impact standard for ERISA preemption that would preclude those taxes from being applied in the manner required by Congress. Nevertheless, these very taxes that Congress has granted states authority to impose have already been held to be preempted in reliance upon the *Travelers* analysis. *See New England Health Care Employees Union v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn.), *appeal pending*, Nos. 94-7264 and 94-7906 (2d Cir. 1994) (hereinafter *"New England Health Care"*). Using the *Travelers* analysis, the district court decided that the Connecticut statute was preempted by ERISA because the uniform sales tax and provider taxes had a substantial economic impact on ERISA plans and because a large percentage of the revenue generated came from ERISA plans. Therefore, the state's taxes were preempted, despite the fact that they were specifically authorized by Congress and despite, indeed because of, the fact that they were applied uniformly to all patients and all hospital revenues as required by Congress.

The Second Circuit's indirect economic impact standard is in conflict with congressional intent to encourage states to enact hospital rate-setting laws and uniformly-applied health care-related taxes. It should, therefore, be rejected.

B. The Court's Precedent Supports A More Balanced ERISA Preemption Inquiry That Does Not Focus On Economic Impact Alone.

The Second Circuit's willingness to rest a determination of ERISA preemption on indirect economic impact alone is also contrary to the teaching of this Court. The Court has consistently relied on other factors that enable it to assess the impact of the challenged state law on the congressional goal of unimpeded interstate operation of ERISA plans, rather than the narrow focus on economic impact utilized in *Travelers*.

In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the Court rejected an ERISA challenge to Georgia garnishment laws despite claims of substantial economic impact. *Id.* at 831; *see also id.* at 842 (Kennedy, J., dissenting). Not only did the Court refuse to find preemption in *Mackey* despite significant economic impact, none of the decisions in which the Court has found ERISA preemption is based on economic impact alone.

Instead, the Court has relied on factors that reflect congressional intent that states not impede multi-state operation of ERISA plans. Thus, in *Fort Halifax Packing Co.*, the Court explicitly addressed lack of impact of the Maine law on multi-state operations. 482 U.S. at 8-14. In *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990), the Court found that the state antisubrogation law would affect the structure of the plan and the administration of benefits in a way that would impair multi-state operation. In other

cases, the Court has found preemption where the challenged law made specific reference to ERISA plans or was premised on their existence. *See Mackey*, 498 U.S. at 830 (express exception for ERISA plans from garnishment law preempted); *Ingersoll-Rand*, 498 U.S. at 140 (cause of action for unlawful discharge to defeat ERISA benefits claim preempted because premised on existence of ERISA plan). State statutes that single out ERISA plans for differential treatment are likely to defeat the goal of unimpeded multi-state operation that Congress sought.

ERISA preemption analysis should reflect these factors used by this Court, rather than the narrow economic impact focus of the Second Circuit. The Third Circuit in *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179, 1994 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), used a balanced approach that assesses the impact in a manner more suited to the purpose of ERISA preemption and is more consonant with this Court's decisions. Echoing the language of *Ingersoll-Rand*, 498 U.S. at 139-40, the Third Circuit described the statute before it in a manner that articulated the proper factors for assessing ERISA preemption:

> In summary, we, too, have before us a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state.

United Wire, 995 F.2d at 1195.[4] These criteria soundly evaluate the impact of state regulation on ERISA plans and ensure the proper freedom from state interference while preserving the state's permissible role.

C. The Travelers Economic Impact Standard Has Already Been Extended To Further Curtail Legitimate State Regulation.

In assessing the impact of the *Travelers* economic impact standard, the Court has the benefit of two subsequent cases that follow and expand on the *Travelers* ruling. Thus, it is not necessary to rely on conjecture about where the Second Circuit's path will lead.

Following on the heels of *Travelers*, the federal district court in Connecticut adjudicated an ERISA preemption challenge to a six percent sales tax on hospital services and an additional assessment on hospital revenues for patient care services, both of which complied with federal Medicaid law because they were applied uniformly to all patients and to hospital revenue from all services. *New England Health Care Employees Union v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn.), *appeal pending*, Nos. 94-7264 and 94-7906 (2d Cir. 1994). The taxes were used to fund a pool from which hospitals were compensated for the cost of providing care to those unable to pay. The court reiterated the *Travelers* conclusion that economic impact on ERISA plans that could

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[4] Alternatively, the similar multi-factor analysis employed by the Eighth Circuit would be preferable to the singular indirect economic impact standard. *See Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992); *see also Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn.), *appeal pending*, No. 94-2237 (8th Cir. 1994).

require the plans to either increase costs or reduce benefits "almost by definition" has an effect on the structure and administration of the plans that warrants preemption. *Id.* at 197.

Moreover, the court in *New England Health Care* expanded the scope of ERISA preemption even further. In addition to the *Travelers* indirect economic impact rationale, the court based its preemption ruling on the ground that the Connecticut law "depends on ERISA plans to accomplish its purpose." *Id.* at 195. This fatal dependence was established merely by the fact that, according to the court, 70% of the revenues generated by the law would come from ERISA plans.

The Second Circuit adopted a similar approach in another post-*Travelers* case, *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) (hereinafter *"NYSA-ILA"*). In that case, the Second Circuit ruled that a New York hospital gross receipts tax (the Health Facilities Assessment or "HFA") was preempted because the tax was directed only at the health care industry. The court stated: "Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them." *Id.* at 827. On this basis, the court ruled that the HFA was not a law of general application, distinguishing it from laws that apply to ERISA plans and to all other segments of society as well. The Second Circuit implicitly declined to follow this Court's approach that examines whether the law is one of general applicability or whether it specifically refers to or is premised on the existence of ERISA plans. *See Mackey*, 486 U.S. at 830; *Ingersoll-Rand*, 498 U.S. at 140.

Although couched in different language, this rationale in *NYSA-ILA* is premised on the same foundation as the "dependence on ERISA plans" reasoning in *New England Health Care*. Essentially, these courts have held that

because a significant percentage of the benefits in the health care field are provided through ERISA plans, state regulation in that field is preempted because it either "necessarily affects" those plans or is dependent on them for its success. No decision of this Court has taken ERISA preemption to that extreme, nor should it.

The Second Circuit in *NYSA-ILA* also expanded the reach of its *Travelers* economic impact approach. In *Travelers*, the court held that a "substantial" economic impact would result in preemption. In *NYSA-ILA*, the court held that in some circumstances, the impact need not even be substantial. The tax at issue in *NYSA-ILA* was only 0.6%, imposed on hospital gross receipts. The district court held this did not create a substantial economic impact warranting preemption:

> The impacts on benefit plans are incidentally economic resulting only in the need for administrative and accounting procedures to comply with the law.
>
> The fact that the tax will leave less money for benefits is not decisive here. . . . The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption.

NYSA-ILA Medical and Clinical Services Fund v. Axelrod, No. 92 Civ. 2779, 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993).

Reversing the district court, the Second Circuit ruled that "[a] statute that 'relates to' ERISA plans cannot escape preemption simply because the magnitude of the impact is thought to be insubstantial." *NYSA-ILA*, 27 F.3d at 828. The court apparently found the requisite connection between the state law and ERISA plans based on two factors. First, the tax was imposed only on the health care industry. *Id.* at 827. Second, the plaintiff plan actually operated medical centers that were directly subject to the

tax. If the first factor, by itself, is sufficient to eliminate the substantiality requirement for economic impact preemption, any state regulation in the health care field that incidentally imposes any additional cost on an ERISA plan would be preempted. Alternatively, if the second factor is enough to warrant preemption, hospitals and other health care facilities owned by ERISA plans would be insulated from the broad range of state economic, professional and safety regulation to which such facilities are now subject. See p. 26, *infra*.

II. THE *TRAVELERS* INDIRECT ECONOMIC IMPACT STANDARD WILL PRESENT A MAJOR IMPEDIMENT TO STATE REGULATION IN THE HEALTH CARE ARENA AND ELSEWHERE.

A. States Have An Enormous Financial And Social Stake In Their Health Care Systems That Cannot Be Addressed Without Some Impact On ERISA Plans.

The responsibility for regulating health care and ensuring that health care services remain available and affordable to everyone in need of them continues to rest with the states. Congress has not enacted substantial national health care reform. Therefore, the states have devised means to increase access to health care for their uninsured and underinsured populations.[5]

States have a crucial stake in the success of these efforts. States spent about $100 billion on health care in 1991. Fernando R. LaGuarda, Note, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 Geo. L.J. 159, 170 n.62 (citing Congressional Budget Office, *Economic Implications of Rising Health Care Costs* 7 (1992)). As

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[5] Robert Pear, *Health Changes as Congress Fails*, N.Y. Times, September 16, 1994 at A1, A22.

noted at p. 1, *supra*, states spend an average of 20 percent of their budgets on health-related programs. Despite these enormous expenditures, many people remain uninsured. See n.12, *infra*. Moreover, costs continue to escalate. For example, from 1990 to 1993, state Medicaid program spending for in-patient hospital services grew from $17.4 billion to $40.4 billion. Prospective Payment Assessment Comm'n, *Analysis of Medicaid Disproportionate Share Payment Adjustments* 2 (Jan. 1994).

When states attempt to contain the costs of or assure fair access to health care, they are faced with the increasingly formidable hurdle of ERISA preemption. The ERISA preemption clause has properly been interpreted to prohibit state laws that require employers to offer health insurance or specific health benefits to their employees or to pay a portion of health care insurance premiums. *See, e.g., Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *cert. denied*, 454 U.S. 801 (1981). Even when ERISA preemption is limited to its proper boundaries, it is a significant obstacle to effective state action in the health care area. See citations at p. 2, *supra*. When courts give ERISA preemption an overly expansive scope, as in *Travelers*, it can make the states' task an impossibility.

The reality facing states as they try to keep health care accessible and affordable is that most people in the United States obtain health care benefits through their employment or the employment of a family member.[6] The Second Circuit in *Travelers* stated that 88% of "non-elderly

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[6] According to the Employee Benefit Research Institute, 62.5% of the non-elderly population have employment-based health insurance coverage. Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured – Analysis of the March 1993 Current Population Survey*, EBRI Issue Brief Number 145 at 1 (January, 1994) (hereinafter "*EBRI Issue Brief*").

Americans have private health insurance through their employee welfare benefit plans."[7] *Travelers*, 14 F.3d at 711. It is also true that most of these employee benefit plans are governed by ERISA.[8] If state laws in the health care field are preempted simply because they affect ERISA plan participants along with all other citizens of a state, no state health care law will survive ERISA preemption. So sweeping a result was not what Congress intended in enacting ERISA, nor what this Court envisioned in its decisions construing the ERISA preemption clause.

B. Preemption Under The *Travelers* Standard Threatens Substantial Amounts Of State Funding For Health Care Access, Much Of Which Is Generated Through Taxes Authorized By Federal Law.

Approximately half of the states have enacted taxes on health care provider revenues in accordance with federal Medicaid law.[9] These states acted for the dual

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[7] It is likely that the court meant that 88% of the non-elderly *who have* private health insurance have it through employee plans.

[8] With certain limited exceptions, all private employers that offer health insurance benefits to their employees are governed by ERISA.

[9] As of September 15, 1991, 27 states used revenues from health care provider taxes, typically based on a percentage of the revenues paid to providers, to help fund their Medicaid programs. *See* H.R. Rep. No. 102-310, 102d Cong., 1st Sess. 3 (1991), *reprinted in* 1991 U.S.C.C.A.N. 1413, 1416. Based on data received from the Department of Health and Human Services, Health Care Financing Administration, and the 1994 State Legislative Survey conducted by the Federation of American Health Systems and published in *Health Systems Review*, Vol. 27, No. 5, September/October 1994, approximately the same number of states continue to use some form of a health care-related tax as a

purpose of increasing access to health care services for low-income people and obtaining matching federal revenue

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vehicle for funding payments to hospitals for the uncompensated care they provide to low-income people and obtaining matching federal revenue for their states. *See, e.g.*, Ala. Code § 22-6-30 (taxes levied on providers of medical services); Ark. Code Ann. §§ 26-52-1401 to -1406 (Michie Supp. 1993) (6% tax on total gross receipts derived from all personal care services provided by a personal care services provider; 2.8% tax on total gross receipts derived by long-term care facilities or nursing facilities; 4.78% on total gross receipts derived by intermediate care facilities for the mentally retarded); D.C. Code Ann. §§ 47-1221 to -1232 (Supp. 1994) (1.5% assessment on hospitals, assessment equal to $11.88 per patient day on nursing homes, assessment equal to $15.29 per patient day on intermediate care facilities for the mentally retarded); Fla. Stat. Ann. § 395.7015 (West 1993) (1.5% assessment on annual net operating revenue for certain health care entities); Haw. Rev. Stat. §§ 346E-1 to -16 (Supp. November 1993) (4% assessment on all hospital income, 6% assessment on all nursing facility income); Ill. Ann. Stat. ch. 305, para. 35-1/2 (Smith-Hurd Supp. 1994) (assessments on hospital, nursing homes and intermediate care facilities for the mentally retarded); Ky. Rev. Stat. Ann. §§ 142.301, 142.303, 142.307, 142.311 (2.5% tax on gross revenues of hospitals; 2% tax on gross revenues of nursing facilities, intermediate care facilities for the mentally retarded, physician services, licensed home health care services and HMO services; $0.25 prescription tax on pharmacies or any other provider dispensing or delivering outpatient prescription drugs); Me. Rev. Stat. Ann. tit. 22, §§ 396-F to 396-I (West 1992) (hospitals transmit percentage of net patient service revenues to hospital payments fund from which payments are made to hospitals for uncompensated care costs); Mass. Gen. L. ch. 118F, § 15 (1990 ed.) (hospital assessments calculated by State Department of Medical Security); Minn. Stat. § 256.9657, subds. 1 and 2 (1992 and Supp. 1993) (assessment of 1.4% of net patient revenues on hospitals, assessment of $535 per licensed nursing home bed, 0.6% surcharge on health maintenance organization total premium revenues); Miss. Code Ann. § 43-13-141 *et seq.* (1972) (with amendments through 1993)

for payments made to hospitals to assist them with their uncompensated care costs. For the states that have enacted these taxes, as authorized by federal law, the ramifications of the *Travelers* decision are particularly disastrous.

As discussed at p. 10, *supra*, in order to qualify for matching federal funds, the state tax laws must apply uniformly to revenue received from all payors for services, except government benefit programs. These laws typically tax health care providers, such as hospitals,

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(assessments on nursing facilities and intermediate care facilities for the mentally retarded); Mo. Ann. Stat. § 208.453 (Vernon Supp. 1994) (hospitals pay a federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care in the state); Mont. Code Ann. § 15-60-102 (assessment of $2.00 per nursing facility bed day for fiscal year 1994 and $2.80 per bed day for fiscal year 1995); Nev. Rev. Stat. § 422.383 (tax on hospitals not to exceed 6% of the net revenue from in-patients); N.H. Rev. Stat. Ann. §§ 84-A:1 to -A:12 (Supp. 1993) (Medicaid Enhancement Tax on gross patient services revenue of every hospital to be established by legislation each biennium); N.Y. Public Health Law § 2807-a(23) to (27) (McKinney 1994) (assessments on hospitals' gross earnings for inpatient services pooled and redistributed); S.C. Code Ann. § 12-23-810 *et seq.* (Supp. 1994) (hospital tax based on total expenditures of each hospital as percentage of total hospital expenditures statewide); Utah Code Ann. § 26-36-101 *et seq.* (Supp. 1994) (Medicaid Hospital Provider Temporary Assessment imposed on each hospital, hospital-based ambulatory surgical facility, and free-standing ambulatory surgical facility); Vt. Stat. Ann. tit. 33, §§ 1950-1958 (assessment of 2% of gross inpatient revenues on hospitals, assessment of $725 per licensed nursing home bed, assessment of 6% of total direct and indirect expenses of intermediate care facilities for mentally retarded); Wash. Rev. Code Ann. § 82.65A.010 (West Supp. 1994) (tax on intermediate care facilities for the mentally retarded); W. Va. Code §§ 11-27-1 to -35 (Supp. 1994) (health care tax on wide variety of health care services and entities).

based on revenues they receive on behalf of patients. In order to comply with the "broad-based" and "uniform" requirements of the Medicaid law, the taxes are imposed irrespective of the patients' status as ERISA plan participants or beneficiaries. *See* n.9, *supra*.

The consequences of the *Travelers* indirect economic impact standard for states with these taxes are severe. ERISA preemption of these taxes will strike at the heart of states' ability to provide health care for those of limited means. For instance, nearly one-fifth of West Virginia's citizens are dependent upon Medicaid to provide essential health care services. Over one-third of West Virginia's total Medicaid revenues are generated by the collection of Health Care Provider Taxes imposed on hospitals and other institutions, as well as on physicians and other individual providers of health care services.[10] The provider tax on hospitals alone (plus associated federal match) funded nearly one-sixth of the State's Medicaid Program in Fiscal Year 1994. Thus, in excess of fifty thousand West Virginia residents (one-sixth of the active Medicaid-eligible population) are dependent on the provider tax on hospitals for essential health care services.

Nor is this threat hypothetical. The *New England Health Care* decision, which relied on the sweeping indirect economic impact test to strike down Connecticut's uncompensated care pool taxes, demonstrates the inevitable, expanding impact of the *Travelers* case on state health care measures. 846 F. Supp. at 197. As a result of the *New*

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[10] West Virginia, due to its low per capita income, enjoys a 3 to 1 federal match ratio. Thus, every dollar raised by its provider tax results in four dollars of funding for its Medicaid Program. Its provider tax revenues of approximately $106 million annually therefore support in excess of $425 million of its $1.24 billion Medicaid Program.

England Health Care decision, Connecticut is in jeopardy of losing approximately $150 million in matching federal funds. Other states that have enacted taxes in accordance with federal Medicaid law will also be forced to forfeit substantial amounts of federal dollars if their taxes are similarly preempted. For example, Massachusetts stands to lose $140-150 million; Vermont would lose approximately $23.1 million; and Montana is at risk of losing approximately $17 million.

In addition to Medicaid-related taxes, other state efforts to finance the cost of comprehensive health care reform will be hampered by an indirect economic impact test for ERISA preemption. For example, the Minnesota health care reform program is a multi-faceted approach that includes cost containment measures as well as a program to provide care to the uninsured. *See* Health-Right Act, ch. 549, 1992 Minn. Laws. 1487; Act of May 24, 1993, ch. 345, 1993 Minn. Laws 1535. It is funded in part by a 2% tax on gross receipts of health care providers. Minn. Stat. § 295.52 (1992). That tax is the subject of an ERISA preemption challenge by several self-insured ERISA plans.[11] *Boyle v. Anderson*, 849 F. Supp. 1307 (D.

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[11] Over half of all U.S. workers are covered by health plans that are self-insured. Human Resources Div., U.S. General Accounting Office, *Health Insurance Regulation* 5 (Dec. 1993). ERISA preemption has generally provided self-insured plans greater insulation from state regulation than insured plans. *See, e.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). An indication of the expansive effect of the *Travelers* indirect economic impact standard is that the New York hospital surcharges were found preempted even though the plaintiffs are insurance companies and the impact at issue was necessarily therefore on insured ERISA plans. Nevertheless, the fact that there are no self-insured plans as plaintiffs in this action does not mean that self-insured plans are not subject to this Court's ERISA analysis. Nor does it mean that the indirect economic

Minn.), *appeal pending*, No. 94-2237 (8th Cir. 1994). The federal district court in Minnesota upheld the tax, rejecting an indirect economic impact argument based on *Travelers*. If this Court holds that indirect economic impact alone is sufficient to warrant preemption, the Minnesota provider tax will fall, as will the ability of all states to use one of the few mechanisms available for funding expansion of health care access.

Another example of a state health care law that would be jeopardized if the indirect economic impact standard is embraced by this Court is New Jersey's Health Insurance Reform Act, challenged in *The Health Maintenance Organization of New Jersey v. Whitman*, No. 93-5775, 1994 WL 549626 (D.N.J. Oct. 3, 1994). The New Jersey legislature found that a number of commercial health insurers were not issuing individual policies because they tended to cover poor risks. The result was that Blue Cross and Blue Shield, with state-mandated open enrollment, were incurring extensive losses. The Act was intended to distribute those losses more equitably among all health insurance carriers in the state. The Act imposes an assessment, based on annual premiums, on all health insurance carriers. An exemption from the assessment is available for carriers who agree to write a certain number of individual policies on an open enrollment basis. An HMO subject to the assessment challenged the Act on ERISA preemption grounds. The federal district court recently upheld the law, relying on *United Wire*'s rejection of the economic impact standard. However, if this Court embraces the *Travelers* standard, the New Jersey plan, like so many other state efforts, will succumb to ERISA preemption.

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impact standard of ERISA preemption is any less flawed as regards self-insured plans.

C. Even State Health Care Laws With A *De Minimis* Effect On ERISA Plans May Be Preempted Under Travelers.

The indirect economic impact test established in the *Travelers* decision also creates an unavoidable "slippery slope." If any state law with an indirect economic effect on ERISA plans is preempted, all state laws regulating health care services are at risk of preemption. States cannot possibly address even the basic regulation of health care, let alone health care reform, if state health care laws that may result in health care facilities increasing their charges to patients are preempted. Because of the way some lower courts have applied *Travelers*, all state laws that are in the health care field could be preempted. *See NYSA-ILA*, 27 F.3d at 827 (uniform assessment of 0.6% on health care facilities preempted because ERISA plans operate in the health care arena).

The result is that the quality of care provided by medical facilities is at risk as a consequence of the *Travelers* decision. States assume responsibility for providing their residents with quality medical care. For example, most, if not all, states maintain extensive licensing laws that require health care facilities to meet minimum standards for ratios of patients to registered nurses, infection control activities, sanitary conditions, dietary and laundry services, maintenance of medical records, etc. *See, e.g.*, Cal. Health and Safety Code § 1254 (Deering Supp. 1994); Ill. Ann. Stat. ch. 210, para. 85/1 *et seq.* (1993) (Hospital Licensing Act); S.C. Code Ann. § 44-7-250 (Law. Co-op. Supp. 1993). States also impose vigorous standards concerning the disposal of medical waste to protect both patients and the general public from unsanitary and dangerous conditions. *See, e.g.*, Cal. Health and Safety Code § 25015 *et seq.* (West Supp. 1994) (Medical Waste

Management Act); Fla. Stat. Ann. § 381.0098, *et seq.* (1993 and Supp. 1994); R.I. Gen. Laws § 23-19.12-1 *et seq.* (Supp 1993); S.C. Code Ann. § 44-93-10 *et seq.* (Law. Co-op. Supp. 1993) (South Carolina Infectious Waste Management Act).

All of these regulations carry a price tag for medical providers. Under the *Travelers* test, these provisions could be preempted. Health care facilities typically include their costs of compliance in charges to patients, and many patients are ERISA plan participants and beneficiaries. The absurd result, therefore, is that states will not be permitted to protect the public health.

Both the Third Circuit and the federal district court in Minnesota have recognized that such a result is untenable. *See United Wire*, 995 F.2d at 1194; *Boyle*, 849 F. Supp. at 1313-17. In both of these decisions, the courts rejected the legal argument that indirect economic impact alone, absent other factors that interfere with the operation of ERISA plans, is sufficient to preempt state health care statutes.

If this Court allows the *Travelers* economic impact standard to be applied to state laws that apply uniformly to health care providers and/or patients regardless of their ERISA status, it is difficult to conceive of any state laws aimed at health care regulation and reform that could withstand an ERISA challenge. This Court must preserve states' authority to regulate their health care systems, consistent with both legislative intent and common sense. Congress did not intend to strip the states of their authority to regulate health care and institute health care reform. Certainly, in the absence of federal regulation, states must be permitted to continue their efforts to

preserve the quality of health care and reduce the substantial number of their citizens who are without access to necessary health care.[12]

D. The Indirect Economic Impact Standard Is Likely To Affect Other Areas Of State Regulation.

ERISA plans provide benefits in other areas besides health care, including education, day care and legal services. State regulation in each of these fields inevitably costs ERISA plans, like everyone else, more than they would otherwise pay for those services. For example, in the day care field, building codes and staffing ratios that seek to ensure the safety of the children and the quality of the program unquestionably increase costs. Under the *Travelers* indirect economic impact standard, states conceivably could be preempted from imposing such quality and safety requirements. Moreover, if an employer or union runs a day care program directly through an ERISA-covered plan, conceivably the Second Circuit, following its decision in *NYSA-ILA*, would hold that the economic impact need not even be substantial to warrant ERISA preemption. Once again the charmed existence

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[12] In 1992, 17.4% of the nonelderly population – 38.5 million people – were not covered by private health insurance and did not receive publicly financed health assistance. This figure represents an increase of 0.8% over 1991 figures (36.3 million people).

In 12 states and the District of Columbia, more than 20% of the population was uninsured in 1992. These states and their uninsured rates were Nevada (26.6%), Oklahoma (25.8%), Louisiana (25.7%), Texas (25.7%), the District of Columbia (25.5%), Florida (24.2%), Arkansas (23.5%), Mississippi (22.7%), New Mexico (22.5%), Georgia (22.4%), California (22.2%), South Carolina (20.8%) and Alabama (20.1%). *See EBRI Issue Brief, supra*, at 1.

created by the economic impact standard would have a consequence that exceeds both congressional intent and common sense.

E. Should The Court Reach A Decision In This Case That The Surcharges Are Preempted Or Are Otherwise Inappropriate, Such Decision Should Not Extend Beyond The Facts Of The Case.

Like New York, other states have engaged in hospital rate-setting activity. Unlike New York, however, whose surcharges treated patients differently based on the identity of the insurer, other states, such as Maryland, for example, do not impose any surcharges.[13] In Maryland, approved rate structures are comprised of various cost elements, and charges are applied uniformly among all payors, including Medicare and Medicaid. In Connecticut, under the Uncompensated Care Pool statute, the costs of uncompensated care were spread more equitably among the state's hospitals. The system taxed all patients the same amount and taxed hospitals on the revenue they received from all patients. It did not differentiate in any way on the basis of the type of insurance coverage that was involved. Similarly, Massachusetts' uncompensated

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[13] The New York surcharges were designed to "level the playing field for the Blues in their competition with commercial insurers." *Travelers*, 14 F.3d at 712. Thus, the Second Circuit noted that the New York surcharges had a "connection with" ERISA plans because they were intended to influence the choices that ERISA plans made for health care coverage by increasing the costs of the less favored alternatives. *Id.* at 719. The court's indirect economic impact standard does not appear to be dependent on this factor. To the extent the Court believes this factor is determinative of the case, the decision should be narrowly limited to similar circumstances of differential treatment.

care pool spreads the costs of uncompensated care more equitably among its hospitals without differentiating on the basis of insurance coverage.

Because hospital rate-setting programs across the country differ significantly from the New York surcharges, and because many states are engaging in other forms of properly authorized health care-related activities on behalf of their citizens, it is respectfully requested that if a decision herein invalidates the surcharges, such decision not be so broad-based as to extend beyond the characteristics presented solely by the New York system.[14]

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[14] The Court should also note that in *Travelers*, the Court of Appeals concluded that the three surcharges imposed a "significant economic burden" based solely on an examination of the surcharges standing alone and not on an analysis of the overall impact of the regulatory scheme in New York. Because hospital rate-setting comprises consideration of many elements, it is not reasonable, or even possible, to evaluate the net effect of a hospital rate-setting system solely on the basis of one element of that system.

The State of Maryland, for example, provides a good example of why a rate system should be evaluated as a whole to arrive at its net impact on ERISA plans. Before hospital regulation in Maryland, Blue Cross plans were the beneficiaries of an approximately 14% discount. Today, under rate regulation, Blue Cross (and any other insurer or HMO that satisfies certain criteria) receives a 4% discount from rates that have been certified as reasonable. Further, although the Maryland system, like others, includes various elements, taken as a whole, hospital costs per admission in Maryland have moved from a level of 25% above the national average in 1976 to a level of 11% below the national average in 1993. As a result of lower than average costs and lower than average mark-up of charges over costs, charges per case in Maryland were less than 64% of the average charges nationally per case in 1992, the last year for which data were available. American Hospital Association, *Hospital Statistics* (1993-94 ed.)

CONCLUSION

ERISA's preemption provision was not intended to eviscerate our principles of federalism. "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' " *Fort Halifax Packing Co.*, 482 U.S. at 19 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)). "We also must presume that Congress did not intend to pre-empt areas of traditional state regulation." *Metropolitan Life Ins. Co., Inc. v. Massachusetts*, 471 U.S. 724, 740 (1985). Thus, the well-established presumption against preemption that ensures the proper respect for federalism concerns is applicable even in ERISA preemption analysis, and particularly so where, as here, a traditional area of state regulation such as health care is involved. The Second Circuit's indirect economic impact standard for ERISA preemption fails to give these principles their due.

For the foregoing reasons, indirect economic impact alone should be rejected as a basis for ERISA preemption, and the decision of the Second Circuit Court of Appeals should be reversed.

Dated: November, 1994

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Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, et al.,

Petitioners,

vs.

TRAVELERS INSURANCE CO., et al.,

Respondents.

(Caption Continued on Reverse Side of Cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, THE MARYLAND HOSPITAL ASSOCIATION, INC., AND THE MASSACHUSETTS HOSPITAL ASSOCIATION, INC. AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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Petitioners,

vs.

TRAVELERS INSURANCE CO., et al.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

vs.

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Interest of the Amici Curiae

Amici curiae the American Hospital Association ("AHA"), the Maryland Hospital Association, Inc., and the Massachusetts Hospital Association, Inc., respectfully submit this brief in support of the Petitioners. All parties have given written consent to the filing of this brief, and the letters so stating have been filed with the Clerk of the Court.

Founded in 1898, the AHA is the primary organization of hospitals in the United States. Its institutional members include approximately 80% of the nation's hospitals, and nearly 50,000 health care professionals hold individual membership.

The AHA's corporate mission is to promote the quality of American health care for all people through leadership and assistance to hospitals and other health care organizations. To fulfill this mission, the AHA regularly participates in the judicial and legislative arena to address important issues concerning federal and state health care reform in general and hospital regulation in particular. The Maryland Hospital Association and the Massachusetts Hospital Association are the leading organizations of hospitals in their respective states and are independent associations whose missions, goals, and concerns are allied with those of the AHA in this matter.

As leaders in the health care field, and as representatives of health care institutions whose continued survival and service to society depend on equitable regulation, apportionment, and reimbursement of necessary costs, amici are vitally concerned that states retain the flexibility to assure equal access to affordable high-quality health care, a goal that will be seriously undermined if the decision of the Second Circuit Court of Appeals is permitted to stand.

Introduction and Summary of Argument

In light of the recent failure to enact comprehensive federal health care reform legislation, and uncertainties as to the future of such federal initiatives, it is likely that the states will be the primary venue of continued reform efforts. New York State has

long been an innovative leader in attempting to provide affordable and quality health care to all of its residents.

States' efforts to implement comprehensive reform legislation, and their efforts to spread health care costs over the widest possible base, have been significantly frustrated by the breadth of ERISA's preemption provision. State laws that, for example, require employers to offer or pay for health benefits, or impose mandated benefits on self-funded plans, or directly tax plans or benefits, have all been held preempted.

The Court is not here called upon to read ERISA § 514(a) more narrowly than heretofore. But this appeal does seek to reverse a judicial extension of ERISA's preemptive sweep that erodes the states' remaining flexibility to regulate and equitably apportion the costs of hospital care among all payors without reference or regard to their status as ERISA plans. An affirmance of the decision below could well leave states essentially powerless to act in the health care field, a result that Congress could not conceivably have intended and is, indeed, directly contrary to its express intent.

In *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), New York's statutory hospital reimbursement system, which regulated the rates of all payors, was upheld against a claim of ERISA preemption. Expressly agreeing with *Rebaldo*'s analysis and reasoning, the Third Circuit likewise held that New Jersey's comprehensive reimbursement statutes were not preempted. *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 and 114 S. Ct. 383 (1993). In the present case, the Second Circuit invalidated the challenged portions of New York's reimbursement statute and, in so doing, disagreed with *United Wire* and disavowed its prior reasoning in *Rebaldo*. 14 F.3d 708, 714, 719-20.

The Petitions for Certiorari herein stressed this conflict in the Circuit Courts and the national importance of the issue presented. That issue is whether states have the power, in

general, to set hospital rates for patients who happen to be ERISA plan participants. If all such state laws are preempted, it is unnecessary to reach the question whether the particular New York rate differentials invalidated below are lawful. It will, however, become necessary in the future for the courts to entertain innumerable ERISA challenges to a wide variety of state laws that indirectly affect plans simply because they potentially increase plans' costs of doing business or potentially decrease contributions to the plans.

We show below that a state's exercise of its inherent police powers to provide for the health and welfare of its citizens through the establishment of mandatory hospital rates is not preempted. First, the purpose of ERISA was not to regulate or preempt generally applicable state laws that affect the price of services to plan participants. Second, state hospital reimbursement systems that establish uniform rates are not superseded because (i) they do no more than substitute for the rights and obligations between patient and hospital that exist under common law; (ii) they do not impact upon ERISA plans other than in a tenuous and remote manner; and (iii) Congress has expressly encouraged states' efforts to control costs through the adoption of all-payor systems. Third, state reimbursement systems that produce disparate rates — such as those resulting from the differentials at issue — stand in no different position vis-à-vis ERISA preemption than uniform rate systems; neither relate to ERISA plans.

ARGUMENT

I

ERISA WAS NOT INTENDED TO PREEMPT STATE LAWS THAT AFFECT THE PRICE OF SERVICES TO PLAN PARTICIPANTS

Congress purposefully preempted broadly and this Court has insisted upon an expansive reading of the statutory text. In *District of Columbia v. Greater Washington Board of Trade*,

_ U.S. _ , 113 S. Ct. 580, 583 (1992), this Court summarized its prior description of the breadth of ERISA § 514(a) as follows:

> "We have repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.' *Shaw*, *supra*, 463 U.S. at 97. *E.g.*, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 829 (1988); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). This reading is true to the ordinary meaning of 'relate to,' see Black's Law Dictionary 1288 (6th ed. 1990), and thus gives effect to the 'deliberately expansive' language chosen by Congress. *Pilot Life*, *supra*, 481 U.S. at 46. See also *Morales v. Trans World Airlines, Inc.*, 504 U.S. _, _ (1992). Under § 514(a), ERISA pre-empts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) 'even if the law is not specifically designed to affect such plans, or the effect is only indirect,' *Ingersoll-Rand*, *supra*, 498 U.S. at 139, and even if the law is 'consistent with ERISA's substantive requirements,' *Metropolitan Life*, *supra*, 471 U.S. at 739.[1]

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[1] Pre-emption does not occur, however, if the state law has only a 'tenuous, remote, or peripheral' connection with covered plans. *Shaw*, 463 U.S., at 100, n.21, 103 S. Ct., at 2901, n.21, as is the case with many laws of general applicability, see *Mackey*, 486 U.S. at 830-838, and n.12, 108 S. Ct. at 2185-2190, and no. 12; cf. *Ingersoll-Rand*, 498 U.S. at 139, 111 S. Ct. at _."

In the present case, the Second Circuit has, in turn, given an expansive reading to this Court's pronouncements and has reached a conclusion that is not only unsupported by any holding or analysis of this Court, but produces a result that

Congress did not and, as a matter of "common sense," could not intend.

Because everything in the cosmos has, in some fashion, an indirect "connection with" everything else, including New York's differentials and ERISA plans, the question in each case is where the line should be drawn between those state actions that do or do not affect plans in too tenuous a "manner." It is the *nature* of the relationship that is significant. "[A]s in any preemption analysis, 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978).

The purpose of ERISA is set forth in the statute itself:

> "[protecting] participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts." [ERISA § 2(b), 29 U.S.C. § 1001(b).]

The object of protecting plan participants and the two means by which such protection is to be afforded — disclosure and fiduciary standards — are thus clear. But the fullest protection accorded to plan participants was not intended to confer on them some special advantage that nonparticipants do not enjoy in matters unrelated to the operation and administration of plans. Participants do not enjoy a "charmed existence that was never contemplated by Congress." *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (quoting *Rebaldo v. Cuomo*, *supra*).

This Court has not limited ERISA's preemptive sweep to state laws that relate to the subject matters regulated by ERISA: disclosure requirements or fiduciary standards. Also superseded are those laws that impair the efficient operation of plans

through burdensome and potentially conflicting administrative requirements. As explained in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), a "patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."

In precluding state interference with the operation and administration of plans, it is significant that ERISA itself imposes no substantive requirements on the content of plans. Employers are free to establish and fund such plans at any level, and plans are free to determine what type and extent of benefits they will provide to their participants. There are no maximum or minimum requirements.

Although ERISA § 514(a) preempts state laws only "insofar as" they relate to "plans," as opposed to benefits, and the statute does not mandate that any particular benefits must be offered, *Fort Halifax* also held that such laws are preempted "if they attempt to dictate what benefits shall be paid under a plan." *Id.* at 13 n.8. The Dissenting Opinion (*id.* at 26) did not disagree on this point. It relied on *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981), as establishing that ERISA's concern was not only with uniformity in the administration of plans, but with "state statutes which require employers to provide particular employee benefits."

The New York laws at issue here neither interfere with plan administration nor require any particular benefits to be provided. They are yet a further step removed and affect only the *price* of hospital services to plan participants, which plans may choose to cover in whole or in part. Even if such laws may indirectly influence plans' decisions as to the level of benefits, they indirectly connect to plans in too tenuous a *manner* to result in preemption.

II

ERISA DOES NOT PREEMPT A STATE'S POWER TO ESTABLISH UNIFORM HOSPITAL RATES

Respondents assert (Br. in Opp. 1, 4, 13, 18) that the State's general power to set hospital rates is neither challenged nor undermined by the Second Circuit's decision herein.[1] This "concession" is made for two strategic purposes: First, they wish to retain all of the *benefits* of State limitations on hospital costs and rates while excising three provisions they find disagreeable — the differentials — from the extensive and unified regulatory scheme. More importantly, they seek to avoid an examination of the issue of ERISA's preemption of the State's rate-setting power because such an analysis dooms the challenge to the differentials. The very reasons *why* the rate-setting power is not preempted also demonstrate that when that power is exercised to produce disparate rates, the same result obtains.

Accordingly, in order to determine whether Congress intended to preempt the New York rate differentials here at issue, we first address (i) the rights and obligations of the

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[1] The District Court in the instant case observed in a *dictum* (813 F. Supp. 996, 1006) that preemption of the State's rate-setting power was a necessary consequence of its decision, but the Second Circuit did not expressly comment on that view. However, in *New England Health Care Union v. Mount Sinai Hosp.*, 846 F. Supp. 190 (D. Conn. 1994) (appeal docketed #94-7264), the District Court, adhering to its reading of the *Travelers* Decision, invalidated Connecticut's statutory Uncompensated Care Assessments (uniformly applicable to all nongovernmentally insured patients) to the extent that such patients were plan participants. As a result of that decision, Connecticut revised its statutes and the revisions are also being challenged as preempted. *Connecticut Hosp. Ass'n v. Pogue, et al.*, No. 3:94 CV 01224 (D. Conn.). In addition, other aspects of New York's reimbursement system are under attack on preemption grounds in *Connecticut Gen. Life Ins. Co., et al. v. Cuomo*, No. 93 Civ. 3648 (S.D.N.Y.) (balance billing law), and *Trustees Of & The Pension Hospitalization Benefit Plan, et al. v. Cuomo, et al.*, 92 Civ. 5589 (S.D.N.Y.) (bad debt and charity care funding provisions).

hospital and patient in the absence of any state regulation and (ii) state reimbursement systems that establish uniform rates. In Point III, we discuss reimbursement systems that, as in New York, produce disparate rates.

In New York, and nationally, patients typically agree to pay the hospitals' charges pursuant to an agreement that is express or implied by law. A hospital will usually accept assignment of a patient's health insurance, if any and from whatever source, but the patient remains personally liable for whatever portion of the hospital's bill remains unpaid by the insurer for any reason — be it a deductible, coinsurance requirement, denial of coverage, or an outright refusal to pay on any basis.

A state's common law will provide the hospital with a cause of action to recover against the patient for any unpaid portion of the bill. In the absence of state regulation of charges, the courts will enforce express contracts to pay the hospital's self-determined charges or allow recovery in *quantum meruit* for implied contracts. In the latter case, the courts will determine the "reasonable value" of services provided.[2]

Are these common law remedies unenforceable when the patient happens to be an ERISA participant? Does it make a difference that the state legislature establishes the hospital's charges rather than leaving that determination to the hospital itself, or for a judge to determine on an *ad hoc* basis?

A. ERISA Does Not Preempt Common Law Causes of Action Against Plan Participants

Although a state's common law is as fully within ERISA's preemptive reach as are its statutes,[3] there is no evidence that

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[2] *E.g.*, *McGuire v. Hughes*, 207 N.Y. 516, 519, 521, 101 N.E. 460 (1913); *Mount Sinai Hosp. v. Burns*, 138 Misc. 2d 381, 527 N.Y.S.2d 678 (N.Y. App. T. 1988); *see St. Peter's Hosp. v. Hall*, 102 Misc. 2d 73, 422 N.Y.S.2d 628 (N.Y. Sup. Ct. Albany Co. 1979) ("the charges are commensurate with those of other area hospitals").

[3] "State laws" preempted by ERISA include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." *(Footnote continued)*

Congress intended to preempt state common law remedies against patients for breach of their implied or express agreements to pay the hospital simply because they happen to be plan participants. To the contrary, suits against ERISA *plans* themselves for "run-of-the-mill state-law claims such as unpaid rents, failure to pay creditors, or even torts" are not preempted. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988). It has been repeatedly held that when plans mistakenly confirm insurance coverage of a participant, and the hospital provides services in reliance thereon, the state law claim against the plan is not preempted. In *Hospice of Metro Denver, Inc. v. Group Health Ins.*, 944 F.2d 752 (10th Cir. 1991), the Court found that the impact on the plan of permitting recovery was too "tenuous, remote, or peripheral"; did not "affect the structure, the administration or type of benefits" of the plan (citing *Rebaldo*); did not threaten inconsistent State and local regulation; and the Congressional purpose in enacting ERISA was not transgressed. *Id.* at 754-55. "Preemption in this case would stretch the 'connected with or related to' standard too far." *Id.* at 756.[4]

If "run-of-the-mill" common law claims against *plans* for misrepresentations of coverage are not preempted, *a fortiori* the same result must apply when a plan *participant* is sued on his express or implied agreement to pay for hospital services. The rights and liabilities that inhere in the hospital-patient relationship exist independently of the patient's insurance, if any, or the patient's relationship, if any, with an ERISA plan.

ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1). Common law causes of action and remedies are thus included. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

[4] *Accord Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Beth Israel Med. Ctr. v. Sciuto*, 1993 WL 258636 (S.D.N.Y. 1993); *Gaston Mem. Hosp. Home Health Serv. Inc. v. Bridgestone/Firestone, Inc.*, 830 F. Supp. 287 (W.D.N.C. 1993); *The Meadows v. Employers Health Ins.*, 826 F. Supp. 1225 (D. Ariz. 1993).

In *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139-40 (1990), the Court reasoned that a state common law claim will be preempted if the "existence of a pension plan is a critical factor in determining liability"; if the "cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself "; and if "a plaintiff must plead, and the court must find, that an ERISA plan exists" to establish liability.

This analysis has consistently been applied to determine whether a state cause of action is preempted and is entirely in keeping with the plain meaning of the statute. State laws are preempted "*insofar as* they may now or hereafter relate to any employee benefit *plan*." ERISA § 514(a) (emphasis added).[5]

The hospital's common law cause of action has no "connection with" ERISA plans because the existence of any type of insurance, whether provided by a plan or otherwise, or its absence, is wholly irrelevant to the patient's individual obligation to pay. The hospital need *not* plead and the court need

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[5] *See, e.g., Fort Halifax Co. v. Coyne, supra*, 482 U.S. at 23 (state severance payment law did not speak to *plans* and was not preempted); *Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270, 287-88 (2d Cir. 1992) (fraud claim preempted because it concerns the conduct of a fiduciary and third party "in relation to the plan. . . . A state common law action which merely amounts to an alternative theory of recovery for conduct actionable under ERISA is preempted"); *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990) (fraud claim against insurance agent not preempted because he was not an ERISA entity); *Monarch Cement Co. v. Lone Star Industries*, 982 F.2d 1448, 1453 (10th Cir. 1992) (contract claim not preempted because defendant, who agreed to fund pension plan, was liable as a seller of a business rather than a principal ERISA entity); *Compare Sanson v. General Motors Corp.*, 966 F.2d 618, 621 (11th Cir. 1992), *cert. denied*, _ U.S. _ , 113 S. Ct. 1578 (1993) (claim of fraudulently inducing employees to resign so as to forego retirement benefits preempted because existence of a plan was "critical" to claim) *with Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1406-07 (11th Cir. 1994) (misrepresentation claim concerning elimination of jobs, not plan benefits, not preempted; state fraud claim functions irrespective of an ERISA plan and "it would defy common sense to allow ERISA to preempt").

not find that an ERISA plan exists to establish liability. The patient is being sued in his or her capacity as a patient who has agreed to pay, not as a plan participant.

Preemption of state common law causes of action to enforce express or implied contracts would confer a "charmed existence" on plan participants (*Rebaldo* at 139) and lead to absurd results that Congress could never have intended. If a hospital simply refused to provide care to ERISA plan participants unless payment were received *in advance*, there would be no state law to apply or preempt. But requiring such "up front" payment "does not serve, but rather defeats, the purpose of Congress in enacting ERISA." *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, *supra*, 904 F.2d at 247; *see Beth Israel Med. Ctr. v. Sciuto*, *supra*, 1993 WL 258636 at *4; *Hospice of Metro Denver, Inc. v. Group Health Ins.*, *supra*, 944 F.2d at 754-56.

Accordingly, the hospital's common law right to collect its charges from a patient subsists notwithstanding the patient's status as a plan participant and notwithstanding a plan's decision to indemnify the patient for all or part of his liability to the hospital.[6] The same is equally true when the hospital's charges are determined by a state.

B. State Rate-Setting

Codifying the common law, a state statute could simply provide that, "in the absence of an express contract, patients are liable for the reasonable value of the services provided." There can be no difference, for preemption purposes, between the

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[6] In *New England Health Care Employees Union v. Mount Sinai Hosp.*, *supra*, the District Court, on the basis of the Second Circuit's decision here, not only invalidated the State's Uncompensated Care Assessments, but also enjoined the hospitals from collecting the assessments from the participants directly, notwithstanding express contracts obliging them to pay whatever portion of the hospital's bill that was not paid by the insurer. 846 F. Supp. at 199-200. This unwarranted preemption of common law rights is more than an analytical tool, but has become a reality in Connecticut.

common law and its statutory embodiment. Nor can there be a difference, if "common sense" illuminates Congressional intent, that the "reasonable value" is legislatively determined pursuant to a detailed statutory reimbursement formula rather than by a judge on an *ad hoc* basis.

New York's reimbursement system, unlike the common law, precludes enforcement of express contracts to pay a negotiated rate (except in the case of HMOs). The statute limits the hospital's right to receive more, and the patient's right to pay less, than the established rate. The result is similar to that obtaining under *quantum meruit*, where a court fixes the maximum and minimum payment at the reasonable value based on costs.[7] Does ERISA preempt either (or both) of these limitations?

1. *Maximum Charges*

In discharge of its Constitutional duty to enact laws that protect and promote "the health of the inhabitants of the State" (N.Y. Const., Art. XVII, § 3), the New York State Legislature has engaged in the most extensive regulation of hospitals, specifying permitted, mandatory and/or prohibited activities, costs and charges in the fullest exercise of its police powers.

The regulation of hospitals' activities has among its goals the control of costs so as to make health care affordable. States' efforts to control rising health care costs is a national phenomenon, and "the regulation of public health and the cost of medical care are virtual paradigms of matters traditionally within the

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[7] New York's statutory reimbursement formula takes a fundamentally different approach. In an effort to coerce hospitals to reduce and control costs, the prospective rate represents what the State determines the services *should* cost, and the actual or reasonable costs incurred are only tangentially implicated. If hospitals incur costs higher than the prospective rate, they are financially penalized; if below, they are rewarded for their efficiency. Beyond these incentives, the State regulates what costs hospitals are permitted to incur: the capital costs of an unauthorized MRI machine are not reimbursable.

police powers of the state." *Medical Soc'y v. Cuomo*, 976 F.2d 812, 816 (2d Cir. 1992), citing *Hillsborough County v. Automated Medical Lab. Inc.*, 471 U.S. 701, 719 (1985). Cost control results in the establishment of the *maximum* amounts hospitals can charge. Hospitals in a strong bargaining position cannot insist on more. Does ERISA preempt such state limitations on what hospitals can charge?

It is no answer, for ERISA preemption purposes, that a state law benefits, rather than burdens, a Plan. *All* state laws that "relate to" a plan are preempted, "even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*, 471 U.S. at 739; *see Mackey v. Lanier Collection Agency & Serv., Inc.*, *supra*, 486 U.S. at 829 (statute that exempted ERISA Plans from garnishment "to help effectuate ERISA's underlying purposes" held preempted).

The only argument that can be made in support of preemption of state limitations on charges is that Congress intended to preempt broadly. But if there must also be an "unmistakable" Congressional intent to intrude on the states' police powers (*Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)), and "relate to" must be given its "common sense" meaning (*Pilot Life Ins. Co. v. Dedeaux*, *supra*, 481 U.S. at 47), then it is impossible to conclude that Congress actually intended to preclude state *limitations* on hospital charges. Not only would such a result not bolster Congress's purpose in enacting ERISA, it is diametrically opposed to decades of Congressional action encouraging state control of health care costs (see pp. 21-23, *infra*).

2. *Minimum Charges*

The affordability of health care is but one goal of state regulation. Access to quality health care is another. Also in the exercise of its police powers, a state attempts to assure access to and the delivery of quality care by precluding payment of less than the established rate. Hospitals must be financially viable to provide quality care and meet the niagara of regulatory mandates

imposed on them — from emergency care to staffing levels to infectious waste disposal. Can a state forbid express contracts to pay *less* than the reasonable value of the services or some other amount that reflects the state's judgment of what is a necessary payment to make quality health care accessible and affordable? Can a state protect those hospitals that are without competitive bargaining power from being coerced into accepting less than may be necessary to fund their operations?[8]

If a state, without offending ERISA, can establish maximums that hospitals may charge, then it must be that it can fix minimums that patients must pay. Wherever the line is to be drawn between what does and does not "relate to" an ERISA Plan, there is no evidence of a Congressional intent to place it between a state's power to establish a ceiling and its power to prescribe a floor.[9]

If there is no preemption of "run-of-the-mill" state law causes of action to enforce implied or express contracts (see p. 9, *supra*), there is no preemption of state hospital rate-setting statutes. Both the common law and statutory rights would "relate to" and have a "connection with" an ERISA Plan in like measure. Enforcement of the maximum/minimum charge established by a state's judges or its legislators equally serves or disserves *Congress's purpose* in enacting ERISA.

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[8] All hospitals are economically compelled to maximize occupancy so as to cover their fixed costs, which approximate 80% of their total costs. Many hospitals could not survive in a competitive environment because of their enormous and disproportionate costs in providing care to the uninsured poor, running teaching programs for interns and residents, and capital expenditures to replace aging plant and equipment.

[9] If, somehow, only the State's minimum charge were preempted, presumably the maximum would have to increase so as to offset the loss of revenue and permit the hospital to survive. New York's hospital rate regulation is not only comprehensive but integrated: the ceilings depend on the floors. The freedom of some plans with substantial bargaining power to pay less at the expense of other plans would seem to be an obscure objective of the ERISA legislation.

C. The Indirect Economic Impact of State Rate-Setting Systems Is Alone Insufficient to Result in Preemption

The Second Circuit held the New York differentials preempted because (i) they forced plans to either increase costs or reduce benefits "and this substantial economic impact could be enough to result in preemption," and (ii) they purposely interfere with the choices that ERISA plans make for health coverage. 14 F.3d at 719-21. Putting aside the specific differentials for the moment (see Point III, *infra*), the proposition that the indirect economic impact of a state rate-setting system is sufficient to trigger preemption is insupportable, unsupported by any decision of this Court, and plainly contrary to Congressional intent.[10]

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[10] After summarizing the general ERISA preemption jurisprudence established by this Court, the Second Circuit did not rely, directly or by analogy, on any decision of this Court as support for its conclusion. Instead, it relied on a series of lower court cases that provide no support for the proposition that an indirect economic impact alone is sufficient to preempt. In each case, a tax or other legal obligation was imposed directly on the plan. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, _ U.S. _, 112 S. Ct. 585 (1991) (tax imposed on administrative fees directly based on benefits paid by ERISA plan; plan itself liable if administrator does not pay; specific Congressional intent found to preempt state taxes on plans); *National Carriers Conf. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (tax on plan benefits paid out); *Morgan Guaranty Trust Co. v. Tax Appeals Tribunal of Dep't of Tax. & Finance*, 80 N.Y.2d 44, 587 N.Y.S.2d 252 (1992) (direct gains tax on sale of ERISA property); *National Elevator Indus., Inc. v. Calhoun*, 957 F.2d 1555 (10th Cir.), *cert. denied*, _ U.S. _, 113 S. Ct. 406 (1992) (minimum wage law uniquely affecting plans, imposing requirements directly on plans and favoring one plan over another); *In Re Michigan Carpenters Counsel Health & Welfare Fund*, 933 F.2d 376 (6th Cir.), *cert. denied*, _ U.S._, 112 S. Ct. 585 (1991) (corporate reorganization law allowing employers unilaterally to alter their obligations to plans in direct conflict with ERISA's substantive provisions); *General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25 (2d Cir. 1989) (law mandating employers to pay particular benefits).

1. *Indirect Economic Impact, National Uniformity, and Administrative Burdens*

As *Fort Halifax* concluded, Congress's purpose was to exempt plans from a conflicting patchwork of inconsistent state regulations that would impose increased administrative costs and burdens upon plans. (See p. 6, *supra*.)

Lack of uniformity in the costs of hospital services is, of course, an immutable fact of life. There is variation nationally: some state systems are cost-based; some are charge-based; some are prospective and based on DRGs; and in some states rates are completely unregulated. Medicaid and Medicare have different systems that recognize geographic differences. Within a state, hospitals' charges and rates differ, depending on a wide variety of factors. Within a hospital, each patient will be charged differently in accordance with the kind and extent of the services rendered.

In the absence of any state rate regulation, uniformity in the costs of doing business — if, indeed, that were a goal of ERISA — would still be unattainable: the hospitals' self-determined charges, or as established on a *quantum meruit* basis, will produce disparate results across state lines and within a state. And the administrative burden upon a plan of paying different prices for each of its participants' hospital bills is unavoidable and slight: a different amount is entered on each check issued.

In *United Wire* (995 F.2d at 1194), the Third Circuit agreed with *Rebaldo*'s conclusion that there "is no valid reason why employee benefit plans cannot be subject to national uniformity despite dissimilarities in their costs of doing business," and that in the absence of state regulation rates will still not be "uniform, even as between hospitals in the same locality." 749 F.2d at 139.

It cannot seriously be contended that lack of uniformity and the administrative burdens that result therefrom are sufficient to preempt a state's rate-setting system. Indeed, that was not the basis for the decision below. Rather, the Court below based its decision on the relationship between price and plan benefits.

2. *Indirect Economic Impact and Plan Benefits*

State-regulated hospital rates have a "connection with" commercially insured ERISA plans as follows: patients are charged (and are liable for) the established price; the plan assumes, through its insurer, whatever portion of the patient's liability it chooses; increases in hospital prices may lead to increased insurance premiums; the greater a plan's costs, the fewer benefits may be available unless the employer increases funding. This connects with plans in "too tenuous, remote or peripheral a manner" to result in preemption. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983).

First, while ERISA preempts laws relating to "plans" and not "benefits," it is now established that states may not prescribe the *types* of benefits that plans must pay. (See p. 6, *supra*.) But this Court has never held that a law is preempted simply because it affects the price of benefits — as does a state-reimbursement system — and thereby may influence a plan's decision as to *its* selection of benefits and the extent of coverage.

Second, if the indirect economic impact of state-mandated rates is enough to preempt, then the common law remedies to enforce an unregulated price must fall as well: requiring the patient to pay *anything* will have a substantial economic impact; exemption from liability or prepayment before services is the only solution (p. 11, *supra*).

Third, if indirect economic impact is the test, the scope of preemption cannot be limited to regulation of hospital prices, but must also encompass all other state laws that increase, directly or indirectly, the plans' cost of doing business. In *United Wire* (995 F.2d at 1193-94), the Third Circuit quoted *Rebaldo*'s analysis as follows:

> "A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.

* * *

The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated."

See also Lane v. Goren, 743 F.2d 1337, 1340 (9th Cir. 1984) ("state laws and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted").

Rebaldo's observations are self-evidently true and remain "good law," notwithstanding that a different portion of its analysis was later rejected by this Court.[11] If economic impact is

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[11] *Rebaldo* concluded that, on the basis of ERISA § 514 (c)(2), a state law must "purport to regulate" a plan to be preempted. This interpretation was rejected in *Ingersoll-Rand Co. v. McClendon*, *supra*, 498 U.S. at 484. *United Wire* concluded that *Rebaldo*'s reasoning otherwise "remains persuasive," and would have been decided the same way post-*Ingersoll-Rand*. 995 F.2d at 1194. In the instant case, the Second Circuit disagreed, erroneously finding that its "fundamental premise" was undermined and

(Footnote continued)

the preemptive trigger, there is no end to the laws that must fall. Beyond direct state regulation of hospital *rates*, there are innumerable state laws that result in increased hospital *costs* that must be passed on to patients — minimum staffing requirements, adherence to sanitary standards, and the like. As *United Wire* observed, state regulation of the disposal of medical wastes "can significantly increase a hospital's cost of doing business and, accordingly, its billing to plan participants." The Court nevertheless concluded that "ERISA was not intended to foreclose a state regulation of this kind." 995 F.2d at 1196.[12]

Similarly, because laws that give an advantage to plans are equally subject to preemption (*Mackey*, *supra*, 486 U.S. at 829), the "economic impact" of state laws *limiting* rates or even hospitals' costs — *e.g.*, disallowing reimbursement for an unauthorized MRI machine — would also be unlawful. After all, as the logic of the "economic impact" theory goes, the lower hospital costs might enable a plan to *increase* the level of benefits to its participants.

Nor, if the test for preemption is economic impact, can the inquiry logically be confined to those laws that influence the price of what plans purchase. An equal impact on the plan results from those generally applicable state laws that affect contributions to plans. Taxes, environmental compliance requirements, safety standards, and the like, all have a strong impact on employers' profits and derivatively on contributions

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"its analysis is poisoned by its discredited belief" that a law must "purport to" regulate plans.

[12] Indicative of the Second Circuit's view of ERISA preemption and the scope of the instant decision, is that Court's recent Opinion in *NYSA-ILA Medical & Clinic Serv. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994). The Court there invalidated New York's 0.6% tax on the gross receipts of all health care facilities because it was applied to two facilities that were owned and operated by ERISA plans. If "economic impact" alone were sufficient to preempt, it would follow that these facilities would be exempt from costly requirements, for example, that only licensed physicians could perform surgery.

that they can and/or will make to fund their plans. *Rebaldo* spoke to such laws as directly applied to plans, but the same economic impact influences plan benefits when consideration is given to contributions by employers — or even by employees.

In *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), a municipal income tax was challenged to the extent that employees' contributions to ERISA plans were made subject to the tax. The Court rejected the claim that the tax's influence on employees' contribution decisions required preemption. It concluded that the tax "affects Firestone employees in their capacity as employees, without regard to their status as participants in an ERISA plan," and any effect on plans is incidental and remote. *Id.* at 556. The Second Circuit's economic impact rationale would apparently dictate a different result.

The statute itself provides helpful guidance in discerning Congress's intent as to the preemption of laws solely on the basis of their indirect economic impact on plans. In 1983, Congress amended ERISA so as to exempt portions of Hawaii's Prepaid Health Care Act, but made clear that this exemption did not shield state tax laws from preemption. The amendment provided that nothing in the Hawaii exemption shall be construed to exempt from the general § 514(a) preemption provision "any State tax law *relating to* employee benefit plans." § 514(b)(5)(B)(i) (emphasis added) [29 U.S.C. § 1144(b)(5)(B)(i)].

Assuming that "relating to" in § 514(b) has the same meaning as "relate to" in § 514(a); that Congress intended to preempt equally expansively with respect to "laws" and "any State tax law"; and that Congress *did not* intend to preempt state income taxes on employers or employees, notwithstanding their indirect economic effect on plans — it is therefore difficult to see how state laws that affect the price of what plans purchase are preempted. Tax laws affect employers and employees without regard to their status as plan sponsors or participants. Rate-setting laws affect patients (and derivatively their plan or non-plan insurers) in their capacity as patients without regard to

their participation. Both costs and revenues may affect plan benefit levels, and the economic impact of state laws on each side of the ledger has an equal — and equally tenuous — connection with plans.

The problem that inheres in finding indirect economic impact, standing alone, a sufficient "connection with" plans to warrant preemption is that there is essentially no limit to state laws that impact — positively or negatively — on plans' costs of doing business or contributions to plans. Difficulties of application aside, such a test for preemption has never been adopted by this Court and was never intended by Congress. The economic impact of a state law — even a substantial economic impact — without more, is insufficient to preempt, just as this Court held in *Mackey, supra*, 486 U.S. at 832. In the case of a state hospital rate reimbursement system there is no more.

D. Congress Did Not Intend to Limit States' Control of Hospital Costs and Rates

That Congress intended to preempt broadly in connection with ERISA plans is not the end of analysis, because Congress *also* intended to accord states wide latitude and flexibility in devising reimbursement systems so as to control and equitably apportion the costs of health care.

Rebaldo examined at length Congressional intent with respect to both subjects (749 F.2d at 135-38), but the Court below did not. If the quest is to discern an "unmistakable" Congressional intent to preempt (*Alessi, supra*, 451 U.S. at 522), that examination cannot ignore 25 years of Congressional encouragement of state cost control and rate-setting systems. And such a review precludes the conclusion that Congress actually intended to preempt state rate-setting systems that establish the rates paid by plan participants. The broadest reading of "relate to," the most expansive view of "connection with," and the fullest appreciation of the effect of "economic impact," cannot lead to that conclusion.

If Congress intended to preclude states from regulating hospital rates for nongovernmental payors, then Congress has repeatedly wasted its time in 1967, 1980, 1983, and 1990 conducting hearings, writing reports, and enacting provisions concerning the authority of the Secretary of Health and Human Services to waive federal Medicare requirements so as to allow Medicare payments to be set by state reimbursement systems. If such state reimbursement systems became unlawful in 1974 with the enactment of ERISA, it is impossible to explain why Congress would continue thereafter to refine the waiver authority in minute detail.

As more fully shown in the Brief of Petitioner Hospital Association of New York State (to which we respectfully refer the Court), Congress recognized that all-payor systems served to control costs, first encouraging and later mandating the Secretary to include Medicare in such systems upon a state's request. Indeed, New York's all-payor system was itself reviewed in 1983 in connection with an expansion of the Secretary's authority. Moreover, it is impossible to reconcile a supposed Congressional intent to preempt states' rate-setting power with its enactment of a "Special Rule" that specifically approved New York's uncompensated care reimbursement system — pursuant to which *all* payors were required to contribute — as satisfying the Medicaid "disproportionate share" requirement. 42 U.S.C. § 1396r-4[e].

In light of Congress's specific approval of New York's requirement that *all* payors share in the costs of uncompensated care, it simply cannot be that Congress intended, *sub silentio*, to exempt ERISA participants and their insurers from participation. It cannot be that Congress's 25-year review and modification of the Secretary's authority to participate in state all-payor reimbursement systems was an exercise in futility because Congress intended all-payor systems to be unlawful. Congress's extensive post-ERISA initiatives for state all-payor rate-setting systems

make it impossible to conclude that it intended to preempt state hospital rate-setting.[13]

III

ERISA DOES NOT PREEMPT A STATE'S POWER TO ESTABLISH DISPARATE HOSPITAL RATES

If state laws that establish mandatory and *uniform* hospital rates for patients do not have a sufficient connection with an ERISA plan to result in preemption, does a system with *disparate* rates somehow cross the line? Such disparate rates result from the application of the differentials here at issue. Unlike the 11% and 9% differentials (as to which amici take no position), the revenue generated by the 13% differential is retained by the New York hospitals and applied to meet their costs of operation.

A. Disparate Rates and the Goals of State Rate-Setting

As noted above, the basic goal of state rate-setting is to assure access to quality health care at a reasonable cost for all of the state's inhabitants. States must retain regulatory flexibility in devising reimbursement systems that will not only control costs, but will produce sufficient revenue for hospitals that are required to meet ever-increasing demands for medically intensive and

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[13] Beyond evidence of a Congressional intent not to preempt a state's rate-setting power, the Secretary's waiver authority would save an all-payor system from preemption by virtue of ERISA § 514(d), which provides that no ERISA provision shall "impair or supersede any law of the United States." Judge Van Graafeiland correctly concluded in *Rebaldo*, 749 F.2d at 139-40, that a finding of preemption would impair the Secretary's authority. (The remainder of the Court took no position on the issue.) The point is that if states' rate-setting power is preempted, if "all-payor" systems cannot lawfully exist, there is no system that the Secretary could choose to adopt in lieu of standard Medicare reimbursement principles. The authority to waive becomes a fiction. The concept of impairment is certainly broad enough to encompass nullification.

expensive services for a growing geriatric population, for AIDS and TB patients, and for drug abusers and their victims.

In the absence of state regulation, a hospital's self-determined charges will be set to attempt to generate sufficient revenue to meet its needs. Whatever costs are unmet by virtue of inadequate Medicare and Medicaid rates, and by serving the uninsured, they will be shifted to paying patients — at least by those hospitals with a strong competitive bargaining position. The lack of a strong incentive to control costs by such hospitals was a principal basis for Congress's encouragement of all-payor systems. For many hospitals that serve a high volume of Medicaid and uninsured patients, such as urban hospitals, cost-shifting is not a realistic alternative funding source. Without state regulation, their continued existence would be threatened and the goal of access to quality care for all citizens would be undermined.[14]

The history and purpose of the 13% differential are fully described in Petitioners' Briefs and demonstrate that the provision of lower rates for Blue Cross patients is an appropriate exercise of the State's power to establish rates generally because the differential touches upon the goals of both cost control and access. As to cost control, the initial purpose of the 13% differential was to *limit* and make uniform the shifting of costs to commercially insured patients, and to recognize the Blues' prepayments to hospitals for working capital. As to access, the financial stability of the Blues is essential to produce sufficient hospital revenues: without such coverage of otherwise

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[14] In *New England Health Care*, *supra*, 846 F. Supp. at 196 n.9, the District Court invalidated Connecticut's Uncompensated Care Assessments and observed that, without state rate-setting, ERISA plans would be free to encourage their participants to avoid urban hospitals that incurred relatively large uncompensated care costs. It seems unlikely that the destruction of hospitals that principally serve the poor was Congress's intent in preempting state laws that relate to plans.

uninsurable patients, hospitals' uncompensated care would rise dramatically.

By establishing lower rates for the Blues (and continuing the historic discount), New York has made appropriate provision for the higher costs incurred by the Blues' high-risk and high-cost patients that result from the State-mandated open enrollment policy, has attempted to provide financial stability for this vital insurer so as to make affordable insurance available through the community rating requirement, and, in the process, has neither transgressed any legitimate ERISA concern, nor crossed the line between tenuous and proscribed state action.

In terms of the goals of rate-setting, New York's reimbursement system operates as a unified whole. The challenge here to the 13% differential is, however, highly selective: the commercial insurers seek to excise one tree from the forest of regulatory provisions while retaining the benefits of state control of hospital costs and permitted charges — here, the base DRG rate. But if, for ERISA preemption purposes, a state can lawfully establish uniform rates, there can be no difference when it sets disparate rates so as to generate sufficient hospital revenue to provide access to quality care. Cost control and access cannot be so easily separated by ritual incantations of the breadth of ERISA's preemptive sweep — particularly in light of Congress's recognition of payor differentials within all payor systems.

As shown in the Brief of Petitioner Hospital Association of New York State, Congress reviewed and specifically approved New York's all-payor reimbursement system in connection with the 1983 Medicare Amendments. *And that New York system did not provide for uniform rates*: Blue Cross received a discount of 12%-15% as compared to commercial insurers. N.Y. Pub. Health L. § 2808-c(1) & (6).

B. The Differentials Do Not Relate to ERISA Plans

1. *"Reference To" and "Depend Upon"*

The patients subject to the 13% differential include:

> "patients eligible for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law or the comprehensive motor vehicle insurance reparations act; or enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis, . . . or insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, and the insurer makes payments directly to the general hospital . . . ." [N.Y. Pub. Health L. § 2807-c(1)(b)].

The statute, on its face, does not refer to an ERISA plan or accord different treatment to plan participants in the same category as nonparticipants. Nor does the statute in its operation accord different treatment: commercially insured patients are liable for, and the insurer will pay, 113% of the DRG rate, regardless of their participation in an ERISA plan. Patients with Blue Cross or HMO coverage will not pay the differentials, regardless of their participation.

The result of the Decision below is to require different treatment: those patients eligible for benefits, for example, under the workers' compensation law and who are plan participants will pay *less* than similarly eligible nonparticipants. Congress did not intend to confer such a "charmed existence" on these patients.[15]

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[15] Ironically, if the New York statute *expressly incorporated* the result below — "all ERISA plan participants are exempt from the differentials"

(Footnote continued)

Accordingly, the statute does not depend upon the existence of an ERISA plan for its operation. That conclusion is not altered by the fact that many plans are commercially insured or that it is anticipated or desired that plans might choose to switch coverage. In that connection, the Third Circuit observed in *United Wire*, *supra*, 995 F.2d at 1192 n.6, that it disagreed

> "that a statute should be preempted solely because the participation of ERISA plans is required as a matter of economics in order for the statute to meet its social goals. This is not what we understand the Supreme Court to have meant in *Greater Washington Board of Trade* when it held that statutes predicated on the existence of ERISA plans 'relate to' such plans. The statute in that case could not be applied without reference to the 'coverage levels set forth in ERISA plans.' As we understand it, it is of no legal consequence if removing ERISA plans from the scene would diminish the likelihood that the statute would meet its social goals. Rather, the test for preemption in this regard is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied. *Greater Washington Board of Trade*, _ U.S. at _, 113 S. Ct. at 583-84."

If the New York statute is found to depend upon the existence of an ERISA plan, difficult questions arise in terms of future application of such a standard. Does preemption hinge upon the market share of Blue Cross vs. commercial insurance?

— it would be preempted because it referred to an ERISA plan. *Mackey*, *supra*. The result would be that plan participants would have to pay the *same* rate as other commercially insured patients who are not participants. But the statute's silence as to ERISA participation does not save it from preemption, according to the Court below, because the only lawful result is, indeed, that participants pay less than nonparticipants. And, implicitly, the only way to accomplish that is to have the result published in F.3d rather than in McKinney's New York Statutes. This is the necessary consequence of the ruling below.

That is to say, if 90% of all ERISA plans within a state had chosen the Blues for coverage — and benefitted from its lower rates — would the differential be barred because 10% of the plans elected commercial insurance with higher rates? Would the preemption consequences differ from state to state depending on market share? The point is that the differentials may make commercial insurance companies unhappy, but they do not restrict a plan's freedom of choice as to coverage, much less its choice of the type of benefits offered.[16]

2. *Structure, Administration and Economic Impact*

Ignoring the discrimination that its holding produces within the category of patients subject to the differential, the Second Circuit focussed instead on the differences between commercial rates and Blue Cross rates. It held that because the differential increased the costs of commercial insurance and made such insurance less competitive with the Blues, an ERISA plan's health care benefits and its choices of coverage are purposely interfered with. Accordingly, it held that the "indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan." 14 F.3d at 708. This analysis and its conclusion are unsustainable for several reasons.

To the extent the reference to "structure" and "administration" of plans means to reflect a concern for administrative burdens flowing from lack of national uniformity, no such

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[16] Elimination of the differential will effectively force the State to provide for uniform rates (if that power is not preempted), but the need to provide sufficient revenue to the hospitals could well lead to an increase in the Blue Cross rate. ERISA plans that have chosen such lower-cost coverage will be disadvantaged. If, as the Second Circuit concluded, making Blue Cross coverage more attractive is preempted, would a new law making such coverage relatively less attractive similarly be preempted? After all, plans with Blue Cross coverage will face increased costs, which might result in a reduction of benefits.

burdens result from the differentials and national uniformity is not an issue. There are no differences in this regard between state rate-setting statutes that mandate uniform rates and those that produce disparate rates. (See p. 16, *supra*.)

Similarly, if economic impact is insufficient to preempt mandatory uniform rates, it is insufficient to preempt disparate rates. (See pp. 17-21, *supra*.) It cannot make a difference, for ERISA preemption purposes, that a hospital bill is $1,000 or $1,130. Both bills — among countless other factors determining price — may affect a plan's choice as to the level of benefits it will provide, but how either price affects "the *type* of benefits furnished by a plan" (14 F.3d at 708, emphasis added) is a mystery.

The commercial insurers have asserted that the higher costs imposed upon them by virtue of the differentials will cause them to pass such costs onto ERISA plans. *Id.* at 720. But wholly apart from the many factors that establish hospital prices, and the many choices that plans have for their insurance coverage,[17] there are countless state laws that impose requirements upon commercial insurers — if that is the plan's choice — and affect the premiums they charge. It would appear to be difficult to distinguish between the differentials (which favor the Blues) and state income taxes (from which the nonprofit Blues are exempt) in terms of the economic impact on commercial insurers and derivative impact on plans that choose commercial insurance for coverage. Both laws create costs that may be passed on to plans (and non-plan insureds) and, it can be argued with equal fervor,

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[17] Plans may insure with Blue Cross at the DRG rate, obtain commercial insurance at 113% of the DRG rate (or 111% for prompt payment), insure through an HMO which pays either a negotiated rate or 113% of the DRG rate, self-insure and pay either 113% of the DRG rate for direct payment or hospital charges (higher or lower than the DRG rate) for indirect payment. N.Y. Pub. Health L. § 2807-c(11)(e).

that plan benefits may thereby be reduced.[18] If the "connection with" such income taxes and plans is too tenuous to trigger preemption, so too is the case of the differentials.

Conclusion

In the end, if the states' power to establish mandatory hospital rates, including disparate rates, is preempted, if the Second Circuit's analysis is correct, the issue before the courts would no longer be whether a law "relates to" an ERISA plan, but whether there is any state law that does not.

However broadly Congress intended to preempt state laws that interfered with the efficient operations and choices of ERISA plans, it did not mean to restrict states in their efforts to provide full and equal access to health care services for all of their inhabitants through the equitable regulation and apportionment of hospital costs. And it did not intend the result below.

For all of the foregoing reasons, the American Hospital Association, the Maryland Hospital Association, Inc., and the Massachusetts Hospital Association, Inc., as Friends of the Court, respectfully urge this Court to reverse the decision of the Second Circuit Court of Appeals.

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[18] As noted above (p. 15n), the Second Circuit relied on several lower court decisions holding state tax laws that directly applied to plan operations or income to be preempted. Whatever the validity of those cases, state tax laws imposed on commercial insurers are one step removed and the connection is one step more tenuous. The differentials, reflected in bills to patients that may or may not be covered by commercial insurance, are two steps more tenuous.

Dated: November 16, 1994

Respectfully submitted,

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Nos. 93-1408, 93-1414 and 93-1415

Supreme Court, U.S.
NOV 16 1994
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioner,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL ASSOCIATION OF COUNTIES, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, NATIONAL LEAGUE OF CITIES, AND U.S. CONFERENCE OF MAYORS, JOINED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

In three related statutes, New York State law imposes different surcharges on the rates hospitals charge, depending on whether the charges are paid by commercial insurers, health maintenance organizations, self-insured funds, or other specified payors. The question presented is whether the surcharges, which apply to hospital care regardless of whether it is provided pursuant to an Employee Retirement Income Security Act (ERISA) plan, are preempted by ERISA insofar as the hospital charges are covered by an ERISA plan.

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In the Supreme Court of the United States

OCTOBER TERM, 1994

No. 93-1408

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

No. 93-1414

MARIO M. CUOMO, *et al.*,
Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

No. 93-1415

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioner,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL ASSOCIATION OF COUNTIES, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, NATIONAL LEAGUE OF CITIES, AND U.S. CONFERENCE OF MAYORS, JOINED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*

Amici, organizations whose members include state, county, and municipal governments and officials throughout the United States, have a compelling interest in legal issues that affect state and local governments. They have a special responsibility to ensure that the States and their political subdivisions have adequate authority to control health care costs and to expand access to health insurance. Given the national government's inability, for more than twenty years, to adopt comprehensive health care reforms, it is crucial that *amici* retain the latitude to devise solutions for our nation's health care problems. New York imposed surcharges on hospital rates to spread costs and to promote the availability of health care coverage. The court of appeals' determination that these state rate regulations are preempted will sharply limit the ability of New York and other States "to try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J. dissenting). *Amici* accordingly submit this brief to assist the Court in its resolution of this case.[1]

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[1] The parties have consented to the filing of this brief *amicus curiae*. Letters indicating their consent have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

1. Section 514(a) of ERISA expressly preempts state laws "relate[d] to any employee benefit plan." 29 U.S.C. § 1144(a). Section 514(a) does not, however, reflect an unambiguous intent to preempt state regulation of health care. The statutory language does not on its face establish the extent to which national power to protect employee benefit plans displaces the States' traditional power to regulate public health. The court of appeals' determination that state hospital rate regulations are preempted under section 514(a) is inconsistent with the presumption against preemption of the States' police powers, and it extends the preemptive effect of the statute far beyond the bounds intended by Congress.

The presumption against preemption promotes the important policy of avoiding unintended intrusions on state authority by requiring that Congress express a "clear and manifest purpose" to preempt the States' police powers. *See CSX Transportation, Inc. v. Easterwood*, 113 S. Ct. 1732, 1737 (1993); *Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992). This presumption applies fully to the interpretation of the scope of an express preemption provision like section 514(a). The court of appeals erred in holding that state hospital rate regulations are preempted under section 514(a). Congress did not have a "clear and manifest purpose" to supersede the States' traditional power to regulate health care providers.

2. The court of appeals' holding that New York's hospital rate regulations are preempted under section 514(a) because they "substantially" or "significantly" increase costs of providing health care services for ERISA plan beneficiaries is an unwarranted limitation of the States' traditional power to regulate health care. The court of appeals' preemption standard deprives the States of the power to explore rate regulation as a means of controlling costs, and it threatens many other important state health care initiatives. Federal courts, for example,

have already invoked the decision of the court of appeals to preempt state taxes on health care providers. *NYSA-ILA Med. & Clinical Serv. Fund v. Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994), *petition for cert. filed*, 63 U.S.L.W. 3371 (U.S. Oct. 21, 1994) (No. 94-745); *New England Health Care Employees' Union, District 1199 v. Mount Sinai Hosp.*, 846 F. Supp. 190, 196 (D. Conn. 1994), *app. pending*, Nos. 94-7264, 94-7906 (2d Cir.). The court of appeals' unduly broad interpretation of the preemptive reach of section 514(a) leaves important health care matters ungovernable by the States and ungoverned at the national level.

ARGUMENT

I. THE COURT OF APPEALS' CONSTRUCTION OF SECTION 514(a) IS INCONSISTENT WITH THE PRESUMPTION AGAINST PREEMPTION OF TRADITIONAL STATE POLICE POWERS

A. The Presumption Against Superseding State Police Power Regulations Applies To The Interpretation Of Express Preemption Provisions Like Section 514(a)

In section 514 of ERISA, 29 U.S.C. § 1144, Congress explicitly allocated regulatory authority over employee benefit plans between the national government and the States. However, the relevant provisions of this section "are not a model of legislative drafting." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)). Section 514(a) is an express preemption clause which is "conspicuous for its breadth" and "establishes as an area of exclusive federal concern the subject matter of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp.*, 498 U.S. at 58 (quoting 29 U.S.C. § 1144(a)). This express preemption provision is qualified by a "savings clause" that restores the States' power to enforce laws

that "regulat[e] insurance," 29 U.S.C. § 1144(b)(2)(A), except as in turn further qualified by a "deemer clause." Under the deemer clause, an employee benefit plan regulated by ERISA is not "deemed" an insurer subject to state insurance regulation.[2] 29 U.S.C. § 1144(b)(2)(B); *FMC Corp.*, 498 U.S. at 58.

Although this Court has developed a specialized body of law interpreting and applying section 514,[3] nothing in ERISA alters traditional preemption analysis. *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 114 S. Ct. 517, 526 (1993). The rules that courts have developed in interpreting section 514, like other bodies of specialized preemption case law, must be understood as elaborations of traditional preemption principles. *See Hawaiian Airlines v. Norris*, 114 S. Ct. 2239, 2243, 2247 n.6 (1994); *Buildings & Trades Council v. Associated Builders*, 113 S. Ct. 1190, 1194 (1993) (both recognizing that particularized labor law preemption doctrines must be viewed against background of basic preemption principles).

Congressional intent is, of course, the key to any determination that state law is supplanted by federal law. *Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597,

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[2] In addition to these three provisions, other subsections also allocate authority between the States and the national government. *See, e.g.*, 29 U.S.C. § 1144(b)(4) (saving generally applicable state criminal laws from preemption under subsection (a)).

[3] *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 114 S. Ct. 517 (1993); *District of Columbia v. Greater Washington Bd. of Trade*, 113 S.Ct. 580 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp.*, 498 U.S. 52; *Mackey v. Lanier Collection Agency and Serv., Inc.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life*, 471 U.S. 724; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Franchise Tax Bd. v. Construction Laborers' Vacation Trust*, 463 U.S. 1 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

604-05 (1991); *see also Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978); *Retail Clerks Int'l Ass'n, Local 1625 v. Schermerhorn*, 375 U.S. 96, 103 (1963). Congress' intent to supersede state law may be stated expressly in statutory terms or it may be implicit in the decision to occupy a particular field of regulation.[4] *Wisconsin Public Intervenor*, 501 U.S. at 604-05. Whether Congress' intent is explicit or implicit, the Court starts with a presumption against preemption of the States' historic police powers. Federal law thus will not supersede state law unless that result is " 'the clear and manifest purpose of Congress.' " *Id.* at 605 (*quoting Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Indeed, in two recent cases, this Court has construed express preemption provisions narrowly in light of the presumption against preemption of the States' police powers.[5] In *Cipollone v. Liggett Group, Inc.*, Justice Stevens noted that the "strong presumption" against preemption of state police powers requires a "narrow" construction of an express preemption provision. 112 S. Ct. 2608, 2618, 2621 (1992). Subsequently, in *CSX Transp., Inc. v. Easterwood*, this Court emphasized that the construction of express preemption provisions in light of the presump-

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[4] Preemption may also occur in a third way, "to the extent that state and federal law actually conflict." *Wisconsin Public Intervenor*, 501 U.S. at 605.

[5] Narrow construction of an express preemption provision in light of the presumption against preemption is consistent with the familiar principle that congressional intrusions on state authority are construed narrowly. *See, e.g., Will v. Michigan Dept. of State Police*, 491 U.S. 58, 65 (1989) (clear statement required to subject States to damages suits in state courts); *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985) (Congress must make its intent to abrogate State's Eleventh Amendment immunity "unmistakably clear in the language of the statute"); *Pennhurst State School v. Halderman*, 451 U.S. 1, 16 (1981) (condition of federal grant imposing costs on States must be stated clearly). *Cf. United States v. Bass*, 404 U.S. 336, 349 (1971) (federal criminal statutes construed narrowly to avoid displacing state power).

tion against superseding state law rests on "the interest of avoiding unintended encroachment on the authority of the States." 113 S. Ct. 1732, 1737 (1993). The Court also restated its exacting standard for preemption: "preemption will not lie unless it is 'the clear and manifest purpose of Congress.'" *Id.* (*quoting Rice*, 331 U.S. at 230).

These basic preemption principles apply with full force here. Congressional intent is the key to determining whether a state law is preempted by ERISA. *See, e.g., Ingersoll-Rand*, 498 U.S. at 137-38; *FMC Corp.*, 498 U.S. at 56-57. In interpreting the language of ERISA's express preemption provision and the insurance saving clause, this Court "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life*, 471 U.S. at 740; *see also Alessi*, 451 U.S. at 522. Under the standard employed in *Cipollone* and *CSX Transp.*, the narrow question in this case is whether Congress had a "clear and manifest purpose" to preempt New York's surcharges on hospital rates.

B. Although The Language Of An Express Preemption Provision Is The Best Evidence of Congress' Intent, The Presumption Against Superseding State Law Determines The Outer Limits Of Preemption

Analysis of the preemptive effect of section 514 "'begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.'" *Metropolitan Life*, 471 U.S. at 740 (*quoting Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985)). If "Congress' command is explicitly stated in the statute's language," preemption of state law is compulsory to the extent of that statement. *Shaw*, 463 U.S. at 95 (internal quotations and citations omitted). When a statute contains an express preemption clause like section 514(a), "the task of statutory construction must in the first instance focus on the plain wording of the clause, which

necessarily contains the best evidence of Congress' preemptive intent." *CSX*, 113 S. Ct. at 1737; *see also Cipollone*, 112 S. Ct. at 2618 (preemptive scope governed by express language).

This Court, focusing on the language of the express preemption, insurance saving, and deemer clauses of section 514, has created a large body of ERISA preemption case law. In particular, the Court has construed section 514(a) broadly and has held repeatedly that "ERISA preempts any state law that refers to or has a connection with covered benefit plans." *Gr. Wash. Bd. of Trade*, 113 S. Ct. at 583 (collecting cases). This broad reading of section 514 effectuates Congress' purpose of ensuring a uniform body of benefits law and "minimiz[ing] the administrative and financial burdens of complying with conflicting directives . . . ." *Ingersoll-Rand*, 498 U.S. at 142.

Although the Court has interpreted section 514(a) broadly, ERISA preemption is not without limits. Certain generally applicable state laws are not preempted. *See, e.g., Mackey*, 486 U.S. at 830-41 (garnishment law); *Gr. Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. Moreover, as a general matter, the Court has also recognized that section 514(a) does not preempt state regulations that have only a "tenuous, remote, or peripheral" effect on employee benefit plans. *Gr. Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1; *Shaw*, 463 U.S. at 100 n.21; *see also Morales v. Trans World Airlines, Inc.*, 112 S. Ct. 2031, 2040 (1992) (express preemption of state laws "relating to" subject matter of Airline Deregulation Act does not extend to laws that affect the subject of the federal statute in a tenuous, remote, or peripheral manner). Thus, notwithstanding the explicit preemptive language of section 514(a), it does not unambiguously require preemption of all state laws that can in any sense be said to be "relate[d] to" an employee benefit plan governed by ERISA.

The presumption against preemption does not call into question either the central importance of the language of section 514(a) or this Court's judgments giving it broad preemptive effect. Nonetheless, because section 514(a) does not unambiguously call for preemption in all circumstances, the presumption against preemption plays a significant role in determining the extent to which state law is preempted.

In *Cipollone*, seven members of this Court agreed that an express preemption provision must be construed narrowly in light of the strong presumption against preemption. *See* 112 S. Ct. at 2618, 2621. Justice Blackmun, joined by Justices Kennedy and Souter, wrote separately to explain why the presumption against preemption applies fully to the construction of an express preemption provision. *See id.* at 2625-32 (Blackmun, J., concurring in part and dissenting in part). Where Congress has spoken directly, albeit ambiguously, to the issue of preemption, "the question is not *whether* Congress intended to pre-empt state regulation, but to what *extent*." *Id.* at 2626 (Blackmun, J., concurring in part and dissenting in part). In determining the extent of preemption, the presumption against preemption means that in the absence of unambiguous evidence, the Court will not "infer a scope of preemption beyond that which clearly is mandated by Congress' language." *Id.* (footnote omitted).

In short, the presumption against preemption of traditional state police powers guides the Court's determination of "borderline" preemption questions where it cannot be said that the express preemptive language of section 514(a) unambiguously dictates supplanting state law. *See Shaw*, 463 U.S. at 100 n.21. It helps determine whether the outer limits of ERISA preemption have been exceeded.

C. Congress Did Not Have A Clear And Manifest Purpose To Supersede The States' Traditional Power To Regulate Health Care Providers

The presumption against preemption of traditional state police power regulations provides important guidance in determining the scope of an express preemption provision where, as in this case, explicit statutory language simply does not address the question whether Congress intended to displace the States' power to regulate the delivery of health care. Congress did devote "considerable attention to the question of preemption," and Congress did adopt in section 514 a somewhat opaque set of provisions explicitly allocating power between the national government and the States. *Hewlett Packard Co. v. Barnes*, 425 F. Supp. 1294, 1298 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978). Congress, however, did not establish in the express terms of section 514(a) the extent to which national power to protect employee benefit plans displaces state power to regulate public health. *See Hewlett Packard*, 425 F. Supp. at 1298-1300 (analyzing legislative history of section 514(a)).

Congress focused on pension benefit plans in drafting ERISA and devoted little attention to welfare benefit plans. *See* D.M. Fox & D.C. Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. Health Politics, Policy and Law, 239, 240-44 (1989). Nonetheless, section 514(a) is drafted in broad terms that apply to both employee pension benefit plans and employee welfare benefit plans. *See* 29 U.S.C. § 1144(a); *id.* § 1002(3). Because employee welfare plans are defined to include health care plans, *see* 29 U.S.C. § 1002(1), the Court has given full effect to the language of section 514(a) and held that States cannot regulate directly the terms and conditions of employee health plans or require employers to offer or pay for health benefits. *Metropolitan Life*, 471 U.S. at 739; *cf. Shaw*, 463 U.S. at

96-100. *See also Standard Oil Co. v. Agsalud*, 633 F.2d 760, 765-66 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981).

Nothing in the statutory language, however, suggests any purpose to displace the States' traditional power to regulate health care. There is simply no evidence that Congress, in determining the preemptive effect of ERISA, considered state health care rate regulation—much less the effect, if any, of such rate regulation on any type of employee welfare plans. *See Hewlett Packard*, 425 F. Supp. at 1298-1300 (analyzing the legislative history of section 514(a)). The statute illustrates Congress' preoccupation with pension plan reform and regulation.[6] Any inference that Congress intended section 514(a) to prohibit state health care regulation is far-fetched, especially because Congress did not consider any substantive federal regulation of health care plans and did not make any provision for substantive federal regulation of state health care providers to be substituted for preempted state regulation. M. Bobinski, *Unhealthy Federalism: Barriers To Increasing Health Care Access For The Uninsured*, 24 U.C. Davis L. Rev. 255, 274-77 (1990); *see* Fox & Schaffer, 14 J. Health Politics, Policy & Law at 240.

The New York hospital rate regulations at issue in this case are designed to control hospital costs and to promote availability of health care coverage. Pet. App. 7-8. These regulations are undoubtedly a legitimate exercise of the State's power to regulate public health and safety. *See Hillsborough County v. Automated Medical Lab., Inc.*, 471 U.S. 707, 715, 719 (1985). There is no evidence that it was the "clear and manifest purpose" of Congress to preempt such a traditional exercise of the State's police power.

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[6] ERISA imposes both substantive requirements and procedural standards on pension plans, and although it also establishes some limited standards for welfare plans, "[i]t does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life*, 471 U.S. at 732.

D. Construed In Light Of The Presumption Against Preemption, New York's Generally Applicable Hospital Rate Regulations Do Not "Relate To" Employee Benefit Plans Within Section 514(a) And Are Not Preempted

In this case, the court of appeals held that three surcharges imposed on hospital rates as part of New York's comprehensive regulation of in-patient hospital rates are preempted under section 514(a).[7] Pet. App. 22-25. The

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[7] After holding that New York's 13% and 11% surcharges were preempted under section 514(a), the court of appeals held that these two surcharges were not saved from preemption under the insurance savings clause, section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Pet. App. 26-27. If, contrary to the argument here, this Court determines that the surcharges are preempted under section 514(a), *amici* adopt petitioners' argument that these two surcharges are properly viewed as insurance regulation and saved from preemption.

The court of appeals also held that the 9% surcharge on HMOs is preempted because "HMOs . . . do not engage in the 'business of insurance' as a matter of law." Pet. App. 29 n.6 (quoting opinion of district court); *see also id.* at 26 n.5. *Amici* submit that this conclusory holding was in error.

While New York has a separate statutory scheme for the regulation of HMOs which is partially, but not fully, integrated with its regulation of commercial insurers, the triggering of the ERISA "savings clause" is not conditioned upon a State's having fully integrated insurance regulation within a single statutory scheme. Many States have separate statutory schemes for HMOs which parallel and are significantly, but not totally, integrated with the States' insurance codes. These separate regulatory structures are designed to reflect operating characteristics of HMOs which differ from those of commercial insurance companies. Although set forth in separate statutory provisions, such state regulatory requirements for HMOs reflect the fact that the regulated function is the assumption of a third party's risk in return for a fixed payment—in other words, insurance. *See In re Estate of Medcare HMO*, 998 F.2d 436, 443-45 (7th Cir. 1993). Moreover, contrary to the assumption of the court of appeals, *see* Pet. App. 26 n.5, the functions of traditional commercial insurers and HMOs are not clearly distinct. Many commercial insurers provide coverage through managed care arrangements which deliver services through pro-

court found that the surcharges "relate to" employee health care benefit plans governed by ERISA because they "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits" and "force ERISA plans to increase either plan costs or reduce plan benefits." *Id.* at 23-24.

In holding that the New York rate regulations are preempted simply because they have an indirect economic impact on ERISA plans, the court of appeals relied almost exclusively on this Court's general directive that section 514(a) should be construed broadly. *See* Pet. App. 20-21. The Second Circuit did not thoroughly review this Court's ERISA preemption cases; it did not justify its holding in terms of the policies served by ERISA's express preemption provision; and it completely ignored the presumption against preemption in determining the outer limits of the preemptive effect of section 514(a). *See* Pet. App. 19-25.

Amici adopt, without repeating, petitioners' arguments that the Second Circuit's extravagant reading of section 514(a) is inconsistent with this Court's ERISA preemption cases. *See also United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179, 1191, 1193 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). Moreover, as petitioners explain, New York's hospital rate regulations are completely consistent with the purposes of ERISA preemption. The national interests in a uniform body of benefits law and in avoiding conflicting administrative directives are not implicated simply because the costs of hospital services, which vary for economic reasons from State to State, may also vary because some States have decided to control health care

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vider networks, as do HMOs. Furthermore, HMOs indemnify their insureds for 20% to 60% of covered expenses in addition to providing benefits through direct delivery of services. *See Estate of Medcare*, 998 F.2d at 446 (under Illinois law "HMOs are . . . the substantial equivalents of domestic insurance companies").

costs. *See United Wire*, 994 F.2d at 1194 (national interests in preemption not compromised by similar New Jersey hospital rate regulations).

The court of appeals' rule extends the preemptive effect of section 514(a) far beyond the bounds intended by Congress. The court of appeals failed to construe the express preemptive language of section 514(a) in light of the presumption against preemption.[8] Consequently, its judgment is an "unintended encroachment on the authority of the States." *CSX*, 113 S. Ct. at 1737. If left undisturbed, the court of appeals' judgment would displace important state health care regulations and initiatives, and it would cast a wide range of health care matters into a regulatory void—ungovernable by the States and ungoverned by the national government.

II. THE COURT OF APPEALS' STANDARD IMPAIRS THE STATES' ABILITY TO DEVISE SOLUTIONS TO SIGNIFICANT HEALTH CARE ISSUES AND CREATES A REGULATORY VOID

While health care reform has failed to materialize at the national level, the States have taken the lead "in devising strategies to expand access to health insurance and contain the growth of health care costs." U.S. General Accounting Office, GAO/HRD-92-70, *Access to Health Care: States Respond to Growing Crisis* 2 (June 1992). The States have attacked "[t]he problems of dwindling access to care and escalating health care costs" because "many state lawmakers . . . conclude[d] that it would be

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[8] In contrast to the Second Circuit, the Third Circuit took the presumption against preemption into account in upholding a set of New Jersey hospital rate regulations that are analogous to the regulations at issue in this case. *See United Wire*, 995 F.2d at 1196 ("[W]e are unwilling to attribute to Congress and § 514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs."). The New Jersey rate regulation scheme was superseded by new legislation on January 1, 1993. *See id.* at 1190.

risky, if not irresponsible, to do nothing and hope that the Congress and the President [would] resolve the health care crisis." Intergovernmental Health Policy Project, The George Washington University, *Health Care Reform: 50 State Profiles* 1 (3d ed. 1994). *See generally id.* (comprehensive survey of current and proposed state efforts to control health care spending, improve quality of care, and expand access to medical care).

ERISA, however, imposes significant constraints on state reform efforts because vast numbers of Americans obtain health care benefits under ERISA plans.[9] *See generally* Patricia A. Butler, *Roadblock to Reform: ERISA Implications for State Health Care Initiatives* (National Governors' Association, 1994). Section 514(a) limits the States' power to implement health care reforms because it prohibits direct state regulation of the terms and conditions of health care plans. Under the "insurance savings" clause, 29 U.S.C. § 1144(b)(2)(A), ERISA does permit the States to achieve some health care reforms indirectly by regulating insurance. State insurance regulations, however, apply only to "insured plans" (ERISA plans that purchase insurance) and, under the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), state insurance regulations do not apply to "self-insured" ERISA plans. "[A]bout 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments." U.S. General Accounting Office, GAO/HRD-94-26, *Health Insurance Regulation: Wide Variation In States' Authority, Oversight, and Resources* 2 (Dec. 1993).

Amici recognize that ERISA places significant limitations on the States' power to reform their health care systems. The States have long undertaken the daunting task of health care reform with a full understanding of

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[9] The great majority of the almost 220 million Americans who have health insurance receive their benefits through public and private employer-sponsored health plans. U.S. Bureau of the Census, *Statistical Abstract of the United States* 118 (114th ed. 1994).

these limitations. *Amici* also recognize that many of these limitations must be addressed by Congress.[10] Nonetheless, the court of appeals' expansive interpretation of section 514(a) creates serious and unwarranted barriers to state regulation. *Amici* accordingly submit that affirmance of the decision below would preclude meaningful state health care reform, a result never intended by Congress.

A. The Court Of Appeals' Standard Preempts Traditional State Regulation Of Health Care

The court of appeals held that New York's hospital rate regulations are preempted under section 514(a) because they "substantially" or "significantly" increase costs of providing health care services for ERISA plan beneficiaries. Pet. App. 23-24. This ERISA preemption standard places many important state health care regulations and initiatives in jeopardy simply because they have an indirect economic effect on ERISA health care plans.

The court of appeals' rationale would require invalidation of state hospital rate regulation and prevent state experimentation with hospital rate regulation as a means of providing hospital care for indigent persons. Many States impose taxes on health care providers as a means of funding their share of medical care under the Medicaid program. The court of appeals' rationale would, however, prohibit these state taxes and deny the States the power to use taxes on health care providers as a component of their comprehensive health care reform programs. Finally, the decision calls into question a broad array of traditional state health care regulations, including licensing requirements for hospitals and physicians, for they, too,

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[10] Some limitations on the States' powers to reform health care are necessarily addressed by congressional amendments to ERISA. *See* 29 U.S.C. § 1144(b)(5) (exemption for Hawaii's law requiring employers to provide health insurance for full-time workers). Washington and Oregon have sought similar congressional relief. *See* H.R. 2870, 103d Cong., 1st Sess. (1993); H.R. 3618, 103d Cong., 1st Sess. (1993).

have the inevitable effect of increasing costs for ERISA plans.

These restrictions on the States' traditional police powers go to the heart of our federal system. The States have long served as laboratories for the exploration of alternative solutions to complex social and economic problems. In the oft-quoted words of Justice Brandeis,

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

In accordance with this tradition, States have long engaged in innovation in health care financing, delivery, and regulation. New Jersey, for example, pioneered the concept of paying hospitals on a per case or diagnosis related ("DRG") basis, a state innovation that preceded the federal Medicare program's "Prospective Payment System." *See* 1 *Medicare and Medicaid Guide* (CCH) ¶ 4200 (1993). Similarly, state laws requiring hospitals to provide emergency care to indigent persons predated the Medicare "anti-dumping" provisions of the 1986 Consolidated Omnibus Budget Reconciliation Act, Pub. L. No. 99-272 § 9121, 100 Stat. 82, 164-67, codified as amended at 42 U.S.C. § 1395dd. *See* Michael A. Dowell, *Indigent Access to the Emergency Room,* 18 Clearinghouse Review 483, 485 (1984). The court of appeals' holding severely compromises the States' ability to continue to explore innovative health care policies.

1. *State Power To Regulate Rates Charged By Hospitals And Other Health Care Providers*

States have experimented with hospital rate regulation for over thirty-five years. Frank A. Sloan, *Rate Regulation for Hospital Cost Control: Evidence from the Last Decade*, 61 Milbank Memorial Fund Quarterly 195, 197 (1983). While the States' programs have varied substantially in their details, mandatory rate-setting programs have reduced hospital and overall health care expenditures, improved hospital efficiency, diminished cross-subsidies across payors, and expanded access for people lacking health insurance. *See* Gerald F. Anderson, *All-Payer Rate-Setting: Down But Not Out*, Health Care Financing Review 35 (Supp. 1991). Today, in addition to New York, three other States—Maine, Maryland, and West Virginia —have mandatory hospital rate-setting laws.[11] The rationale of the court of appeals would lead to invalidation of these laws to the extent that they increase the costs of hospital services purchased by an ERISA plan.

The adverse impact of the court of appeals' preemption standard on the States' power to regulate health care through rate regulation is illustrated by considering hospital rate-setting as a means of financing "uncompensated care" for uninsured, low-income persons. The States of Maine, Maryland, West Virginia, and New York include the cost of each hospital's uncompensated care in the rates charged to all private payors, including ERISA plans.[12] These four schemes vary in detail, but share the goals of maintaining hospital solvency and ensuring equitable access to hospital care by spreading the cost of

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[11] Me. Rev. Stat. Ann. tit. 22, §§ 382(16-A), 396; Md. Health-Gen. Code Ann. §§ 19-216—19-219; W. Va. Code §§ 16-29B-19—16-29B-21.

[12] *See* Code of Maine Rules, 90-460, ch. 372; Md. Regs. Code tit. 10, § 10.37.10.03D; W.V. Code St. Reg. §§ 65-5-5.9.7—5.9.9; N.Y. Pub. Health Law § 2807-C(14); N.Y. Comp. Codes R. & Regs. tit. 10, § 86-1.65.

uncompensated care across all purchasers of hospital services.

The New York, Maine, Maryland, and West Virginia uncompensated care rate regulations are vulnerable under the rationale of the court of appeals. In each State, the cost of providing care to indigent persons will be passed on to all purchasers of hospital services, including ERISA plans. These increased costs will then force health care plans governed by ERISA either to increase plan costs or to reduce plan benefits. Under the reasoning of the court below, this indirect economic impact on ERISA plans is sufficient to preempt these traditional police power measures.[13]

In addition to circumscribing the States' power to regulate hospital rates, the court of appeals' decision could also be applied to preempt state rate regulation of other types of health care providers. For example, it could interfere substantially with proposals in Minnesota and other States to regulate rates charged by all health care providers. Minnesota, for example, has enacted a comprehensive health care act. *See Boyle v. Anderson*, 849 F. Supp. 1307, 1309 (D. Minn. 1994). Rate regulation is an integral part of this reform program, and the State will regulate rates paid to health care providers who are not part of integrated plans. Minn. Stat. Ann. §§ 62P.01-62P.05; *see* Commissioner, Minnesota Department of Health, *Implementation Plan and Recommendations for Integrated Service Networks and a Regulated All-Payer Option* 2 (Feb. 1994). State officials have determined that rate regulation of health care providers is necessary to implement an efficient and effective health care financing and delivery system, but the reasoning of the

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[13] New York's provisions for funding uncompensated care are the subject of a pending preemption challenge. *Trustees of the Pension, Hospitalization, and Benefit Plans v. Cuomo*, No. 92-CV-5589 (E.D.N.Y.).

court of appeals would preempt this exercise of state rate-setting authority to the extent that it imposes substantial costs on ERISA plans.

2. *State Power To Tax Health Care Providers*

Under the court of appeals' standard, section 514(a) could also prohibit state taxes on hospitals and other health care providers. Another panel of the Court of Appeals for the Second Circuit recently held that a 0.6% tax on the gross receipts of hospitals and other medical facilities is not *de minimis*. *NYSA-ILA Med. & Clinical Serv. Fund v. Axelrod*, 27 F.3d 823, 828 (2d Cir. 1994), *petition for cert. filed*, 63 U.S.L.W. 3371 (U.S. Oct. 21, 1994) (No. 94-745). In direct reliance on the reasoning of the court of appeals in this case, the panel held that the state tax was preempted because it increased the costs of providing health care to beneficiaries of ERISA plans. *Id.* at 827-28.

Most state taxes on health care providers are imposed under authority explicitly granted by Congress in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, codified at 42 U.S.C. 1396b (w).[14] Although these taxes are an important part of state efforts to fund their share of Medicaid costs, a federal court has already invoked the court of appeals' decision in this case to hold that a Connecticut hospital tax is pre-empted. *New England Health Care Employees' Union, District 1199 v. Mount Sinai Hosp.*, 846 F. Supp. 190, 192, 196-98 (D. Conn. 1994), *app. pending*, Nos. 94-7264, 94-7906 (2d Cir.).

In addition, Washington and Minnesota have established provider taxes as integral parts of their comprehensive health care reform programs. *See* Minn. Stat.

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[14] Many States impose taxes on hospitals under this statute. *See* Br. *Am. Cur.* State of Connecticut *et al.* at 18 n.9.

Ann. § 295.52; Wash. Rev. Code Ann. § 48.14.0201. A district court has held that the Minnesota tax on health care providers did not have a substantial economic impact on ERISA plans and rejected a preemption argument that was based on the opinion below in this case. *Boyle*, 849 F. Supp. at 1315-17. However, the economic impact standard may now be a significant barrier to this state tax because *Boyle* was decided before the Second Circuit concluded that there is no *de minimis* exception to its preemption standard. *Compare Boyle*, 849 F. Supp. at 116 *with NYSA-ILA*, 27 F.3d at 828.

3. *State Power To Set Health Care Standards*

Many traditional state health care regulations, like information reporting requirements and quality of care standards, increase costs of providing medical care. *See, e.g.*, Cal. Code Regs. tit. 22, §§ 70401-657 (setting standards for a wide range of specialized hospital services such as burn, cardiac surgery, and newborn care units); New Jersey Department of Health, *Licensing Standards for Hospitals* § 8:43G-17 (1993) (minimum nursing staff levels for hospitals). Hospitals, pharmacists, doctors, and other health care providers ordinarily pass these increased costs on to health care consumers, including participants in health care plans governed by ERISA. To the extent that these regulations "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," they, too, would be preempted under the court of appeals' reasoning.[16] Pet. App. 23.

State health care data reporting laws illustrate that there is no apparent stopping point to the court of appeals' theory of preemption based on indirect adverse economic impact. Many States have enacted laws requiring health care providers to report information such as "type of services provided, charges, patient information

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[16] Indeed, the subsequent opinion of the court of appeals in *NYSA-ILA* suggests that substantiality may no longer be an issue in the Second Circuit. *See* 27 F.3d at 827-28.

and outcomes, and type of insurance coverage." *Health Care Reform: 50 State Profiles*, at 15. These data collection laws "play a key role in [States'] cost containment and reform initiatives." *Id.* Nevertheless, collecting, analyzing, and reporting information may impose substantial, if not easily quantifiable, costs on health care providers, and the parties subject to these data reporting requirements may well try to pass the costs of compliance on to ERISA plans and other health care consumers. A recent attack on the data reporting requirements of Minnesota's new health care reform act suggests that concerns about the impact of the court of appeals' preemption standard on traditional state health care regulations are not unwarranted. *See Boyle*, 849 F. Supp. at 1311-12.

B. Preemption Of Traditional Police Power Regulations Will Leave Important Health Care Matters Ungovernable By The States And Ungoverned At The National Level

Carried to its logical conclusion, the reasoning of the court of appeals would give rise to a regulatory void. As shown above, the court of appeals' decision has already led to legal challenges asserting that section 514(a) preempts the States' power to regulate hospital rates and to provide charitable or "uncompensated" medical care for indigent persons. Moreover, if left to stand, the court of appeals' interpretation of section 514(a) will undoubtedly prompt additional challenges to other exercises of the States' traditional power to regulate health care. This expansive judicial interpretation of section 514(a)'s preemptive effect is particularly troubling because ERISA makes no provision for substantive regulation of employer health plans.[16]

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[16] *See Health Care Reform: 50 State Profiles*, at 3 n.1 ("Although ERISA preempts state regulation, there is no parallel federal regulation of employer health plans at this time.").

Given Congress' long-standing inability to enact comprehensive federal health care regulation, the Court should reject any interpretation of section 514(a) that would lead to the creation of a regulatory void.[17] In a closely analogous case, the Court interpreted several statutory provisions explicitly allocating regulatory authority between the States and a federal regulatory agency in order to avoid creating a regulatory void and to preserve from preemption a traditional area of state regulation. *Pacific Gas & Electric Co. v. State Energy Resources Conservation & Development Comm'n*, 461 U.S. 190 (1983). The Court first found that the Atomic Energy Acts of 1946 and 1954 gave the national government exclusive authority over radiological safety standards for commercial nuclear power plants and that Congress had left "no role . . . for the States." 461 U.S. at 206-07. After noting that Congress had not given the national government any authority over the economic aspects of nuclear power generation, the Court, in keeping with the presumption against preemption, concluded that the States must retain this type of regulatory authority because "[i]t is almost inconceivable that Congress would have left a regulatory vacuum." *Id.* at 207-08.

Although the Court found that this interpretation of the statute was reinforced by other sections of the statute expressly saving state authority, *see id.* at 208-12, it construed the national government's exclusive power over radiological safety narrowly for the specific purpose of preserving the States' traditional power to regulate the economic aspects of the operation of electric utilities.

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[17] This Court has consistently rejected any interpretation of federal law that could create a regulatory void. For example, the Court has often refused to hold that state law remedies are preempted where federal law provides no comparable or alternative remedy. *See, e.g., Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984); *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656, 663-64 (1954); *see also Cipollone*, 112 S. Ct. at 2630 (Blackmun, J., concurring in part and dissenting in part).

Indeed, the principle of avoiding a regulatory vacuum with regard to the economic aspects of nuclear power plant construction was so important that the Court was willing to tolerate some risk that the States would exercise their authority over economic matters to accomplish radiological safety objectives that are the exclusive responsibility of the national government. *Cf. Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 256 (1984) (noting "tension between the conclusion that safety regulation is the exclusive concern of the federal law and the conclusion that a State may nevertheless award damages based on its own law of liability").

State regulation of health care is at least as important as state regulation of the economic aspects of electric power generation. There is no reason why this Court should construe section 514(a) to create a regulatory vacuum with regard to important health care issues. A narrow construction of section 514(a) is required by the presumption against preemption. It is also consistent with this Court's cases holding that state laws are superseded where "the bite of pre-emption" has been eased by congressional provision of a substitute for the pre-empted state laws. *Cipollone*, 112 S. Ct. at 2630 (Blackmun, J., concurring in part and dissenting in part); *see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990) (comprehensive federal civil enforcement scheme fills void created by preemption of state common law claim); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-56 (1987) (same); *see also Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825 (1988) (preemption of one state garnishment law does not create a regulatory void because a second state garnishment law is not preempted).

In this case, there are no substitute national regulations to fill the void that is created by the court of appeals' construction of section 514(a). There is no basis for believing that Congress, in enacting ERISA, intended to

leave hospital rates, doctors' fees, medical care for indigent persons, and similarly vital health care matters ungoverned until such indefinite time in the future that Congress chooses to fill the regulatory void. Although there undoubtedly are some adjustments of state and national power that require congressional attention, it would stand the presumption against preemption of traditional state police powers on its head to insist that the States must overcome the inertia of the national legislative process and secure statutory relief from the court of appeals' interpretation of section 514(a). To the contrary, the burden should be on Congress to make an explicit decision displacing the States' traditional power to regulate the delivery of health care. Congress did not make that decision in the language of section 514(a).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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Nos. 93-1408, 93-1414 and 93-1415

IN THE
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OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,

Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,

Respondents.

MARIO M. CUOMO, GOVERNOR OF NEW YORK, *et al.*,

Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,

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HOSPITAL ASSOCIATION OF NEW YORK STATE,

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v.

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Respondents.

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BRIEF FOR NYSA-ILA WELFARE FUND, LOCAL NO. 807 LABOR-MANAGEMENT HEALTH FUND, DISTRICT COUNCIL OF IRON-WORKERS OF NORTHERN NEW JERSEY WELFARE FUND, SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND, STEAMFITTERS WELFARE FUND, LOCAL UNION NO. 475, AND TRUCKING EMPLOYEES OF NORTH JERSEY WELFARE FUND AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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Interest of the *Amici Curiae*

The *amici curiae* are collectively-bargained employee welfare benefit plans covered by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C.A. §§ 1001-1461 (West 1985 & Supp. 1994), that provide hospital and healthcare benefits to tens of thousands of unionized workers and their beneficiaries in various industries in New York and other Northeastern states. The *amici* and other ERISA plans are the intended beneficiaries of the congressional protections afforded by ERISA pre-emption. The *amici* thus have a vital and compelling interest in the ERISA pre-emption issue now before the Court. Indeed, one of the *amici* plans was induced to change its method of providing benefits as a direct result of the New York legislation.[1]

SUMMARY OF ARGUMENT

ERISA pre-empts state laws that relate to — *i.e.*, have a connection with — ERISA plans. Petitioners would have this court narrow this broad pre-emptive provision to exclude state laws of general application that have only an indirect, economic effect on ERISA plans. This revisionism is incompatible with the express language of ERISA, its underlying congressional purposes, its legislative history, and earlier decisions of this Court. A statute whose efficacy depends upon the forced participation of ERISA plans, whose operation involves the plans' essential function of administering benefits, and whose effect is to require ERISA plans to either change their method of providing benefits or spend up to 24% of their assets for the benefit of non-beneficiaries must relate to ERISA plans. Petitioners' requested retrenchment of ERISA's "relate to" standard must come from Congress, not this Court.

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[1] All parties have consented to the filing of this amicus brief. The parties' written consents have been lodged with the Clerk of the Court.

ARGUMENT

The Challenged New York Legislation Is Related To ERISA Plans And Thus Pre-empted

The state government, hospital industry, and Blue Cross interests which comprise Petitioners seek this Court's pruning of the most expansive pre-emption clause in history. ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any [ERISA-covered] employee benefit plan." 29 U.S.C.A. § 1144(a) (West 1985). [2]The plain and explicit language of ERISA's pre-emption clause as well as the historical record of its legislative passage reveal a clear and unambiguous congressional intent to preserve exclusive federal regulation in the field of employee benefit plans in order to achieve ERISA's legislative purposes.[3]

ERISA was promulgated principally to protect the interests of plan participants by assuring "the soundness and stability of plans with respect to adequate funds to pay promised benefits." 29 U.S.C.A. § 1001(a) (West 1985); *see Northeast Dep't IL-GWU Health & Welfare Fund v. Teamsters Local 229 Welfare*

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[2] Petitioners' attempt to salvage their case by invoking the insurance savings clause, 29 U.S.C.A. § 1144(b)(2)(A) (West 1985), should be rejected out of hand. On its face it is disingenuous to call the New York hospital rate-setting regime an insurance law when it applies to entities which are manifestly not in the business of insurance — self-insured funds, state and local governmental agencies, and even private uninsured individuals. *See* N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993).

[3] *See* 120 CONG. REC. 29,197 (1974) (statements of Rep. Dent.), *reprinted in* 3 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (Committee Print compiled by the Senate Subcommittee on Labor of the Senate Committee on Labor and Public Welfare) (hereinafter "ERISA LEGIS. HIST."), at 4670-71; 120 CONG. REC. 29,933 (1974) (statements of Sen Williams), *reprinted in* 3 ERISA LEGIS. HIST., AT 4745-46; 120 CONG. REC. 29,942 (1974) (statements of Sen. Javits), *reprinted in* 3 ERISA LEGIS. HIST., at 4770-71; S. REP. NO. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 ERISA LEGIS. HIST., at 621; H.R. REP. NO. 533, 93d Cong., 1st Sess. 12, 17 (1973), *reprinted in* 2 ERISA LEGIS. HIST., at 2359, 2364.

Fund, 764 F.2d 147, 163 (3d Cir. 1985) ("Resolution of the issue will affect not only the interests of beneficiaries, whose welfare it was the prime purpose of ERISA to protect, but also the interests of benefit trust funds, the solvency of which was a matter of serious congressional concern"); *see also Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 48, 52, 587 N.Y.S.2d 252, 254, 257 (1992). To that end Congress adopted in ERISA "standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans," *see* 29 U.S.C.A. § 1001(b) (West 1985), including the requirement that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." 29 U.S.C.A. § 1103(c)(1) (West Supp. 1994).[4]

This Court has articulated the controlling test for determining the meaning of "relate to": every state law that has a connection with or reference to an ERISA employee benefit plan relates to that plan and is pre-empted, whatever the state law's underlying purpose and intent. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. __, 113 S. Ct. 580, 583 (1992); *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). The "relate to" standard must be given "a broad common sense meaning," *see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990). This touchstone does not limit ERISA pre-emption only to state laws specifically designed to regulate the terms and conditions of employee benefit plans or those dealing with the subjects of

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[4] This mandate reaffirms for all ERISA plans the identical "exclusive benefit" requirements enacted by Congress as far back as 1947 in the Taft-Hartley Act, *see* 29 U.S.C.A. § 186 (West 1978 & Supp. 1994), for joint labor-management plans created in collective bargaining. The "exclusive benefit" provisions prohibit the use of trust assets to benefit persons other than plan participants and their beneficiaries. *In re Typo-Publishers Outside Tape Fund*, 478 F.2d 374, 375-76 (2d Cir.), *cert. denied*, 414 U.S. 1002 (1973); *Blassie v. Kroger Co.*, 345 F.2d 58, 68 (8th Cir. 1965).

regulatory concern covered by ERISA — reporting, disclosure, fiduciary responsibility, and the like. *Ingersoll-Rand*, 498 U.S. at 137; *Shaw*, 463 U.S. at 98. Pre-emption prevails even if the state law is not specifically designed to affect ERISA plans or the state law's connection, reference, or effect is only indirect, *see Greater Wash. Bd. of Trade*, 113 S. Ct. at 583; *Ingersoll-Rand*, 498 U.S. at 139; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), or the state law is "consistent with ERISA's substantive requirements," *see Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

The Second Circuit had no difficulty finding that a state law that cost ERISA plans in excess of $1.5 billion has a connection with those plans. Now Petitioners try to escape the self-evident by asking this Court to ignore the plain language of ERISA and redefine "relate to" so as to exclude from ERISA pre-emption any state law of general application that has an indirect, economic effect on ERISA plans. Petitioners' suggested revision is incompatible with the will of Congress.

State laws of general application do not enjoy a privileged position under ERISA. [5]The only mention of a law of general application appears in ERISA § 514(b)(4), which exempts from ERISA pre-emption "any generally applicable criminal law of a State." 29 U.S.C.A. § 1144(b)(4) (West 1985). No other generic law of general application is afforded special treatment.[6]

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[5] In any event, the New York legislation, limited as it is to only a certain segment of society, hardly qualifies as a law of general application. *NYSA-ILA Medical & Clinical Serv. Fund v. Axelrod*, 27 F.3d 823, 827 (2d Cir.), *pet. for cert. pending*, No. 94-745 (U.S. filed Oct. 21, 1994).

[6] Because of the categorical application of ERISA's pre-emption clause to state laws of general application, only Congress can save specific state enactments from ERISA's pre-emptive reach. Hawaii's Prepaid Health Care Act, generally applicable to all employers in that state, would have been pre-empted by ERISA despite its status as a law of general application, were it not for an express congressional dispensation. *See* 29 U.S.C.A. § 1144(b)(5) (West 1985 & Supp. 1994); *see generally Retirement Fund Trust of Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266, 1277-78 (9th Cir.

Indeed, state tax laws, which sweep broadly and usually apply to the entire taxpaying public, were explicitly singled out by Congress to assure that there would be no misunderstanding that they are subject to ERISA's express pre-emption clause, regardless of their general applicability. When ERISA was originally considered, Congress rejected a request by the Secretaries of Labor and Treasury to exclude state tax laws from ERISA pre-emption. *Northwest Airlines v. Roemer*, 603 F. Supp. 7, 12 (D. Minn. 1984). In 1983, when Congress amended ERISA to exclude Hawaii's healthcare regime from the pre-emption clause, it added a specific provision, 29 U.S.C.A. § 1144(b)(5)(B)(i) (West 1985), reaffirming that ERISA's pre-emption clause applied to state tax laws. *See* H.R. CONF. REP. No. 984, 97th Cong., 2d Sess. 18 (1982), *reprinted in* 1982 U.S.C.C.A.N. 4603.

1990) (explaining the legislative history of the special exception afforded Hawaii's healthcare legislation under ERISA). New York and other states which have either adopted healthcare legislation or are contemplating legislation in this area are well aware of the limits imposed by ERISA pre-emption. These states know exactly where to go for remedial relief. They have united in informal coalitions and *ad hoc* groups, which have adopted the strategy of each state petitioning Congress to enact a special waiver exempting that state's regulatory regime from the restrictions of ERISA pre-emption. *See Preemption: States, Employers Expect Battle Over ERISA Restrictions Next Year*, 21 Pens. & Benefits Rep. (BNA) 1838 (Sept. 26, 1994); *State Reform: States To Pressure Congress For ERISA Exemptions To Enact Reforms*, 21 Pens. & Benefits Rep. (BNA) 1867 (Oct. 3, 1994); *Preemption: ERISA Waivers Would Create Legal Nightmare, Attorney Says*, 21 Pens. & Benefits Rep. (BNA) 1983 (Oct. 10, 1994). While New York has put a gun to the heads of ERISA plans by obtaining special legislation amending the Internal Revenue Code to disallow tax deductions if plans do not pay the New York surcharges, *see* Omnibus Budget Reconciliation Act of 1993, PUB. L. No. 103-66, § 13442(a), 107 Stat. 568 (1993), amending 26 U.S.C.A. § 162(n) (West Supp. 1994), the campaign for ERISA waivers has not met with the same success. Recently, Congress did not enact the waiver sought by the State of Washington for its Health Services Act. *See Report Proposals: Washington To Pursue Reforms Despite Lack of ERISA Waiver*, 21 Pens. & Benefits Rep. (BNA) 1987 (Oct. 17, 1994).

Petitioners would limit pre-emption to laws that actually regulate the administration of ERISA plans or impede their interstate operations. *See* Brief For Petitioners Mario M. Cuomo, et al. at 10-11; Brief For The United States at 13. Under this construct state laws having purely economic effects on ERISA plans would not be pre-empted. In Petitioners' view statutes which regulate the administration of ERISA plans have a connection with them; statutes which could destroy them do not. Congress, however, did not share this view. It specifically refused to exempt from the pre-emptive sweep of ERISA state tax laws whose effect is purely economic.

Ultimately Petitioners' case relies upon the canard of characterizing the New York scheme as nothing more than honest hospital rate-setting, which only indirectly and incidentally raises the costs of healthcare purchased by ERISA plans. Petitioners equate the New York scheme with laws that regulate medical waste disposal, hospital staffing, utility rates, and other state regulation which results in increases in the cost of doing business. *See* Brief For Petitioners Mario M. Cuomo, et al. at 24-25; Brief For The United States at 13. That equation does not balance.

The New York scheme does not merely happen to ensnare the ERISA plans along with other healthcare purchasers. It cannot function effectively without the plans' enforced participation. This is manifest from petitioners' conduct in the litigation. They successfully sought a stay first from the district court and then from the court of appeals on the ground that the decision below by exempting ERISA plans from the surcharges would vitiate the whole system.

The exactions and regulations to which Petitioners attempt to liken the New York scheme affect ERISA plans as they do all others in society in their roles as employers, purchasers, and regulated businesses. The surcharges, however, which both the district and circuit courts found to be revenue-producing measures, *see* 813 F. Supp. at 1000; 14 F.3d at 713, affect ERISA

plans *qua* employee benefit plans; they exact their tribute from the very activities and functions that make employee benefit plans what they are — the provision of healthcare benefits.[7]

The difference between the New York scheme and legitimate state regulation that may increase costs is that the New York legislation's sole purpose — and the sole reason why it increases costs — is to provide benefits to persons not covered by ERISA plans. Neither the catchword "indirect" nor the concealment in the Byzantine disguise of a single section 80 pages long, *see* N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993), can obscure the true nature of the New York scheme. ERISA plans are being required either to spend almost a quarter of their assets to provide healthcare for strangers rather than for their beneficiaries or to change their method of administering and providing benefits.[8] To say that the law which mandates this result has no connection with ERISA plans is to defy reality.

Congress enacted in ERISA a deliberately broad preemption provision, which this Court has consistently refused to

[7] This gives rise to a very practical consideration to be factored into the equation. In ERISA Congress encouraged management and labor to establish welfare plans for employees and their dependents. Employers and employees covered by ERISA plans will not passively sit by and continue to fund medical benefits for workers merely to permit states to siphon off the monies the contracting parties believed would be held in trust. Ironically, the indirect economic impact test advanced by Petitioners will cause the opposite of its intended effect by inducing collective-bargaining negotiators to reduce or eliminate employee welfare benefits in favor of wages or some other form of compensation that the workers can keep, thus aggravating the underlying healthcare crisis. As their past practices attest, employers and unions favor using available assets to create and fund welfare plans. In so doing they perform a real public service, consistent with the congressional purposes embodied in ERISA of fostering and encouraging these plans. But one cannot realistically expect these plans to accept the role of wet nurse to the rest of society.

[8] In 1992 *Amicus Curiae* NYSA-ILA Welfare Fund abandoned its traditional policy of self-insurance and contracted with Empire Blue Cross/Blue Shield in order to gain the advantage of the Blues' preferential exemption from the surcharges.

water down, that protects ERISA plans from rapacious state revenue-enhancing regulatory schemes. Petitioners ask this Court to dismantle the barrier that Congress has erected and let the feeding frenzy begin. Their request is as misdirected as it is mischievous. If congressional policy is to be revamped, recourse must be sought, as Petitioners well know, *see supra* note 6, in the halls of Congress, not in the chambers of this Court.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Second Circuit should be affirmed.

Dated: New York, New York
December 12, 1994

Respectfully submitted,

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Nos. 93-1408, 93-1414, 93-1415

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD *Petitioners,*

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*, *Respondents.*

MARIO M. CUOMO, *et al.*, *Petitioners,*

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*, *Respondents.*

HOSPITAL ASSOCIATION OF NEW YORK STATE, *Petitioners,*

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*, *Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENTS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

No. 93-1408

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*,

Respondents.

No. 93-1414

MARIO M. CUOMO, *et al.*,

Petitioners,

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*,

Respondents.

No. 93-1415

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENTS

INTRODUCTION

The National Coordinating Committee for Multiemployer Plans ("NCCMP") urges this Court to affirm the decision of the Court of Appeals for the Second Circuit and to rule that diagnosis related group ("DRG") surcharges are preempted by ERISA, in particular, as applied to self-funded multiemployer plans. All parties to this proceeding have consented to the NCCMP's request to file a brief *amicus curiae* in support of Respondents, and letters confirming their consent have been provided to the Clerk of the Court.

Petitioners in effect urge this court to create a judicial exemption from ERISA preemption for state health care financing statutes on the grounds that these laws fall within traditional state police powers and serve an important social goal. In advocating this position, Petitioners disregard the fact that ERISA plans, in particular, self-funded multiemployer plans also serve an important social function,[1] have limited resources, and are subject to specific federal restraints. More importantly, Petitioners and their *amici* minimize the legal significance of the fact that New York's hospital rate-setting law, because of its selectively-imposed surcharges, disproportionately burdens such plans, and thereby either threatens the ability of these plans to continue to provide benefits or directly influences the choices by which benefits can be provided—results that are not only inimical to the general objectives of ERISA and the specific goal of ERISA preemption but could actually lead to an increase in the population of uninsured citizens.

The Second Circuit, holding that the surcharges imposed by the New York law are preempted as applied to ERISA plans, issued a ruling that is clearly consistent with the plain language of ERISA's preemption provision as well as with every decision of this Court which has

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[1] *See Lewis v. Benedict*, 361 U.S. 459, 468-470 (1960).

interpreted the scope of ERISA preemption. Petitioners, however, recommend a "cost of doing business" standard to determine whether a state law of purported general applicability—despite its selective and inordinate impact on ERISA plans—should nevertheless be given full regulatory effect on the grounds that economic burdens, however onerous, are too tenuous, remote, and peripheral to trigger ERISA preemption. More importantly, Petitioners and their *amici* argue that a state law's economic impact alone, even if substantial, does not constitute a sufficient "connection" to ERISA plans to cause the law to "relate to" the plan within the meaning of Section 514(a) of ERISA.[2]

As the NCCMP will show, this approach ignores the economic reality in which self-funded multiemployer plans operate. Moreover, the NCCMP is concerned that if the Petitioners' standard is adopted in connection with New York's hospital rate-setting statute, there will be no principled basis upon which to draw the line in favor of preemption in other cases, unless the particular state law expressly refers to employee benefit plans or contains a direct mandate. Since most state laws of purported general applicability do not expressly reference ERISA plans, or could be drafted to avoid such express reference, the NCCMP is concerned that if a law's economic impact is entirely excluded from the preemption analysis, self-funded plans (whose resources are limited) will be increasingly compelled to contribute towards the costs of other state health programs or to other social programs not related to health on the grounds that the state-mandated diversion of fund assets is a "mere" cost of doing business in the state[3]

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[2] Section 514(a) of ERISA, 29 U.S.C. 1144(a), provides that "the provisions of this Title and Title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."

[3] Arguments raised in the *amicus* brief of the States of Minnesota *et al.* confirm that this specific concern is justified. *See* Brief, p. 26.

Such a result would not only erode the financial soundness of multiemployer plans, but would undermine the goals Congress sought to promote through ERISA's preemption provision; namely, to insulate employee benefit plans from all state regulations that affect the administration, structure, or solvency of such plans, except for those matters which Congress—in the exercise of its legislative powers—expressly exempted.

INTEREST OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The NCCMP is a nonprofit, tax-exempt organization that was formed after the enactment of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001-1461 ("ERISA"), to participate in the further development of employee benefits legislation, government regulations promulgated to implement ERISA, and other laws affecting multiemployer plans. Currently, more than 240 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans are representative of all of the nation's multiemployer plans, which cover more than nine million workers.

As noted above, New York has enacted a hospital rate-setting statute which imposes DRG surcharges, payable by multiemployer plans, that have no relation to the services provided or the benefits received by the plan's participants and beneficiaries. Although the surcharges were purportedly designed to implement social goals deemed important to the state, the Second Circuit held that the surcharges were preempted as applied to ERISA plans. The NCCMP has a strong interest in seeking affirmance of the Second Circuit's opinion, as DRG surcharges have already adversely affected NCCMP affiliates, which represent a majority of participants in self-funded multiemployer plans.

Because of the broad range of the NCCMP's constituent organizations and its contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary principles, the NCCMP believes that it is qualified to advise the Court of the practical implications of the decision below for self-funded multiemployer plans and to state the position of the trustees, participants, and beneficiaries of such plans.[4]

The NCCMP endorses the reasoning of the District Court for the Southern District of New York [5] and the Court of Appeals for the Second Circuit,[6] and therefore supports Respondents in seeking affirmance of the court of appeals' decision. Respondents have correctly demonstrated why New York's law should be preempted because of its direct influence on a plan's choice of insurer. In this brief, the NCCMP will focus primarily on the adverse impact which cost-shifting laws like New York's will have on the ability of self-funded multiemployer plans to provide high-quality, cost-effective health care through mechanisms of their own choosing.

SUMMARY OF ARGUMENTS

In seeking affirmance of the Second Circuit's decision, the NCCMP supports Respondents in urging this Court to rule that New York's DRG surcharges, which differentially and disproportionately burden all ERISA plans and impermissibly influence their choices for providing benefits, are preempted by ERISA. Nevertheless, to the

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[4] The NCCMP has participated as an *amicus curiae* in numerous cases involving important issues affecting multiemployer plans. *See, e.g., Local 144 Nursing Home Pension Fund, et al. v. Demisay*, 113 S. Ct. 2252 (1993); *Concrete Pipe & Products of California v. Construction Laborers Pension Fund for Southern California*, 113 S. Ct. 2264 (1993); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

[5] *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

[6] *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993).

extent distinctions exist, the NCCMP believes that it is urgent for the Court to consider at this time the impact of the surcharges and similar cost-shifting mechanisms on self-funded ERISA plans, in particular, multiemployer plans, and to clarify that the surcharges are preempted as applied to those plans.

The NCCMP rejects Petitioners' "cost of doing business" standard. In the NCCMP's view, DRG surcharges should be declared preempted—even without regard to their specific economic impact—because this type of cost-shifting, by definition, directly "relates to" ERISA plans. Alternatively, if the cost-shifting effect of New York's surcharges is characterized as the indirect result of a state law of general applicability, Congress's concern with the financial soundness of ERISA plans compels this Court to weigh the economic impact of the surcharges. In addition, even in the absence of cost-shifting, there is nothing in ERISA, its legislative history, or this Court's precedents to support the view that the economic impact of a state law, even one of purported general applicability, should be excluded from the preemption analysis merely because the economic impact of the law is alleged to be indirect or because its effects—whether direct or indirect—are solely economic.

The impact of New York's law imposing DRG surcharges is neither indirect nor purely economic. Moreover, cost-shifting statutes like New York's are not only economically threatening to multiemployer plans; they are also inconsistent with fundamental principles of ERISA and affect trustees' fiduciary obligations with respect to maintaining a sound funding policy and deploying fund assets in the sole and exclusive interest of plan participants and beneficiaries.

Mischaracterizing DRG surcharges as a cost of doing business in the state, Petitioners are in effect requesting this Court to create a judicial exemption for state health care financing laws. However, such an exemption would impermissibly intrude upon an area reserved exclusively

to Congress. The language of ERISA Section 514 does not tolerate judicial exemptions for state laws relating to ERISA plans, even if those laws serve useful social purposes. Rather, § 514(a) supersedes *all* state laws relating to employee benefit plans other than those which Congress expressly exempted.

Congress knew how to draft an express exemption for state health care financing statutes and did so for Hawaii's Prepaid Health Care Act, 29 U.S.C. § 1144(b)(5)(A). More recently, legislative efforts have been made—to date unsuccessfully—to enact additional exemptions for other state health care financing laws, including DRG statutes similar to New York's. Pending national health care reform, or Congressional action with respect to state health care financing laws, this Court should reject the "cost of doing business" standard, adopt a preemption standard that will require courts to invalidate state laws imposing selective and differential burdens on ERISA plans, such as DRG surcharges, and clarify that economic considerations may justify preemption even if a state law is facially neutral.

ARGUMENTS

I. NEW YORK'S DRG SURCHARGES, BY DEFINITION, "RELATE TO" ERISA PLANS; MOREOVER, THE SECOND CIRCUIT'S PREEMPTION ANALYSIS CORRECTLY TAKES INTO ACCOUNT THE ECONOMIC BURDEN OF THOSE SURCHARGES.

A. This Court should clarify that New York's law imposing DRG surcharges is preempted as applied to self-funded multiemployer plans.

As a threshold matter, the NCCMP urges this Court to consider (separately, if necessary) the impact of New York's law imposing DRG surcharges on self-funded multiemployer plans and to decide that this law is preempted as applied to these plans.

Petitioners and other *amici* (including the United States) concede that the New York law at issue in this case encompasses self-funded ERISA plans and imposes a 13 percent surcharge on those plans. It is likewise acknowledged that self-funded ERISA plans may choose to provide benefits through HMOs, in which case the 9 percent surcharge assessed on HMOs that do not meet the state's goals for enrolling Medicaid patients will increase the costs of providing health benefits because the 9 percent assessment will be passed on to the plans in the form of higher rates.[7]

In view of the New York law's inclusion of self-funded ERISA plans, the United States in its *amicus* brief concedes that "application of the 13 percent surcharge to 'self-insured funds' may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves." *See* Brief, p. 12, n.5. Stressing that its brief is addressed only to insured plans, however, the United States urges this court

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[7] *See* Brief of Respondent New York State Health Maintenance Organization Conference *et al.*, in opposition to Petition for Certiorari, p. 18.

not to decide the question of whether the surcharges are preempted as applied to self-insured plans. Rather, the United States requests this Court to remand that issue to the court of appeals and (if necessary) to the district court to determine whether that issue has been properly presented in the case and, if so, how it should be resolved in light of the Court's ultimate decision. Petitioners themselves have not made such a request, and the NCCMP strongly objects to this suggestion of the United States for the following reasons.[8]

First, the United States has conceded that some of the complaints filed in this case include one or more self-insured plans and the fiduciaries of such plans. *See* Brief, p. 12, n.5. Therefore, self-funded plans and their trustees were before the courts below. Moreover, as Respondents' briefs opposing the Petition reveal, the courts below were fully aware of the fact that self-insured plans were within the reach of New York's rate-setting law and subject to the impact of that law. Because the courts below found that the surcharges "related to" all ERISA plans and were not laws regulating insurance within the meaning of the savings clause, the courts did not need to treat self-funded plans separately from insured plans, either for purposes of the preemption provision, the savings clause, or the deemer clause.[9] Since the courts below clearly included

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[8] Noting that over half of all United States workers are covered by self-insured plans, the States of Minnesota *et al.*, as *amici* for Petitioners, also urge the Court to resolve this issue. *See* Brief, p. 22, n.11.

[9] The "savings" clause, Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), provides that "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities." The "deemer" clause, Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), provides in pertinent part—that "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts . . . ."

the subset of self-funded ERISA plans within the ambit of their rulings, it is appropriate and necessary for this Court to include self-funded plans in its present considerations (even if distinctions do prove necessary) as nothing would be gained from further litigation below in light of well-established applicable precedent. Moreover, self-funded multiemployer plans will be exposed to irreparable harm through delay, *infra*.

Second, Petitioners requested *certiorari*, in part, to resolve a conflict between the Second Circuit's *Travelers* decision and the Third Circuit's *United Wire* decision.[10] In *United Wire* (and the multiple related cases objecting to New Jersey's DRG surcharges), plaintiffs were almost exclusively self-funded multiemployer plans and their trustees. Accordingly, a preemption standard applicable to self-funded plans is particularly important at this time, as both *Travelers* and *United Wire* have generated further conflicting decisions involving self-funded plans. *See NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) and *New England Health Care Emp. Union Dist. 1199, SEIU AFL-CIO v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn. 1994) (following Second Circuit); *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994), *appeal docketed*, No. 94-2237 (8th Cir. May 18, 1994) (following Third Circuit).

Third, Petitioners request this Court to rule that even if New York's DRG surcharges "relate to" ERISA plans, they should be "saved" from preemption under Section 514(b)(2)(A) of ERISA as a law regulating insurance. Since this Court has firmly established a bright-line legal distinction between insured and self-funded plans for purposes of applying the "savings" clause, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *FMC*

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[10] *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir. 1993), *cert. denied*, 114 S. Ct. 382 (1993).

Corp. v. Holliday, 498 U.S. 52 (1990),[11] it is appropriate and necessary for the Court to consider the application of the surcharges to self-funded plans in the event it finds that the surcharges "relate to" all ERISA plans but are "saved" from preemption as state insurance laws. It may be noted that the district court has already ruled, and the court of appeals has at least implicitly affirmed that the "13% surcharge referring to self-insured plans could not possibly fall within the savings clause because . . . self-insured plans do not engage in the 'business of insurance' as a matter of law." (Pet. App. A-79.)

Finally, an incomplete decision with regard to the scope of preemption would be extremely detrimental to self-funded multiemployer plans, which have already been adversely affected by the *United Wire* decision and can anticipate further adverse consequences in the event New York's DRG surcharges are upheld without a consideration of their impact on self-funded plans. This is particularly true since other states may be encouraged to enact cost-shifting statutes similar to that of New York, pending national health care reform, *infra*.

In *United Wire*, Judge Nygaard, in a strong dissenting opinion favoring preemption, explained how the New Jersey DRG surcharges would impose a staggering economic burden on ERISA plans:

> The surcharges are paid not by the general public at large, but by the less than 25 percent of the popula-

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[11] As noted above, *supra* n. 9, self-funded ERISA plans are "deemed" not to be insurers or engaged in the business of insurance with respect to state laws "saved" from preemption as laws regulating insurance. Accordingly, in *Metropolitan Life*, this Court exempted self-funded plans from the reach of state-mandated benefit laws while holding that such benefits had to be included in commercial insurance policies even though such policies are marketed to ERISA plans. Similarly, in *FMC Corp. v. Holliday*, the Court exempted self-funded plans from the reach of state anti-subrogation laws, although insured plans will continue to be subject to the antisubrogation provisions of state automobile insurance laws.

> tion who use hospital services. Of those 25 percent, about 75 percent receive the uncompensated care assessments challenged here. ERISA plan participants comprise only about 15 percent of the hospital patients, but pay about 40 percent of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.

995 F.2d at 1199. Indeed, one NCCMP affiliate, the Hotel Employees and Restaurant Employees International Union Welfare Fund, advised that in 1992 and the first months of 1993, it had placed $1,172,096.14 into escrow pending the outcome of the litigation. (A further $533,503.25 was paid under protest.)

Although the courts below did not quantify the precise economic impact of the New York surcharges, they clearly believed that a 13 percent surcharge on a DRG rate whose components already included factors other than the actual cost of providing the covered benefit resulted, in the aggregate, in a sufficiently substantial burden to trigger preemption. While Petitioners and their *amici* dispute the impact, and regard even a substantial economic burden as part of the cost of doing business in the state, they do not seriously deny that the New York surcharges impose significantly higher costs on ERISA plans that could alter plan design.

Given the obvious economic impact of New York's DRG surcharges on self-funded multiemployer plans, the absence of certainty with regard to preemption is clearly harmful, as limited fund assets continue to be diverted into the coffers of hospitals, the state, or into escrow accounts and away from their primary purpose of paying benefits to eligible workers and their families.

Moreover, the need for certainty has become particularly acute as a result of the Omnibus Budget Reconciliation Act of 1993 ("OBRA '93"), P.L. No. 103-66, 107 Stat. 312, § 13442, 26 U.S.C. § 162(n). As Respondents have noted in their briefs opposing the Petitions filed in

this case, Congress amended Section 162(n) of the Internal Revenue Code relating to business deductions, apparently in anticipation of the district court's *Travelers* decision but before the court of appeals issued its ruling confirming that the surcharges are preempted. In effect, the amendment provides that employers will lose their tax deduction for any amounts paid or incurred in connection with a group health plan (including a self-funded plan) if the plan does not pay the 13 and 9 percent surcharges for services provided by New York hospitals between February 2, 1993, and May 12, 1995.

The Conference Committee Report specifically states that "[n]o inference is intended as to whether any provision of the New York all-payer hospital reimbursement system is preempted by ERISA." H.R. Conf. Rep. No. 213, 103rd Cong. 1st Sess. 734 (1993), *reprinted* in 1993 U.S.C.C.A.N. 1088, 1423. Therefore, it is arguable that the loss of the tax deduction was not intended to apply in the event the New York law is declared invalid. Nevertheless, Respondents indicate (and the NCCMP concurs) that few multiemployer plans were willing to risk the consequences of nonpayment even after the court of appeals ruled that the surcharges were preempted and unenforceable, although some plans advised hospitals that they were escrowing amounts equivalent to the surcharges pending an ultimate determination by this Court.[12]

This situation, however, places the trustees of multiemployer plans in an anomalous and untenable position. On the one hand, they need to assure contributing employers that the plan will comply with the surcharge requirement so that the employers will not bargain out of the plan in response to the potential loss of a significant

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[12] Although Section 162(n) is scheduled to expire in May 1995, this issue is not moot for several reasons. First, the provision may very well be extended; second, considerable amounts of money are in escrow; third, at least some plans have refused to pay the surcharges.

tax deduction.[13] On the other hand, the payment of surcharges under a law which the court of appeals has declared is preempted raises substantial fiduciary implications. For example, such payments arguably violate Section 403(c)(1) of ERISA, 29 U.S.C. § 1103(c)(1), because they ultimately "inure to the benefit" of employers by preserving their tax deduction for contributions. Moreover, since payment of the surcharges is unrelated to benefits received by participants, and ultimately inures to the benefit of nonparticipants, payment of the surcharges arguably also violates Section 404(a) of ERISA, 29 U.S.C. § 1104(a), which imposes on trustees a fiduciary duty to expend fund assets solely and exclusively to pay benefits to participants and beneficiaries except to defray the reasonable costs of trust administration.

While a favorable ruling by this Court would not serve to repeal Internal Revenue Code Section 162(n), employers contributing to multiemployer plans would be better able to challenge the loss of a tax deduction in the event a plan refuses to release the money from its escrow account or otherwise fails to comply with the law. Indeed, it is unlikely that the Treasury Department would seek to enforce the amendment in that circumstance. More importantly, such a ruling would undoubtedly shift the focus of attention from the courts to Congress, where a more permanent resolution of the preemption issue properly belongs. As will be discussed below, New York and other states have expressly requested Congress to waive preemption for their health care financing laws. The NCCMP submits that this is the correct way for states to obtain permission to "experiment" with these matters.

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[13] Adverse tax consequences and/or increased contribution rates necessitated by cost-shifting laws clearly offer employers incentives to bargain out. Since ERISA's withdrawal liability provisions (29 U.S.C. §§ 1381-1461) apply only to withdrawals from multiemployer pension plans, and there are no corresponding provisions for health plans, employer withdrawals from multiemployer health plans could ultimately result in the demise of these plans.

In sum, the NCCMP respectfully requests that this Court address and resolve the issue whether New York's DRG surcharges are preempted as applied to self-funded multiemployer plans, as further delay will expose these plans to irreparable harm. As we shall now show, existing precedent requires a ruling that ERISA preempts the DRG surcharges as applied to these plans.

B. Petitioners' "cost of doing business" standard is inimical to the financial health of multiemployer plans.

It is now well established that ERISA was enacted to promote the financial stability of employee benefit plans and to assure that American workers receive the benefits upon which they rely. *Nachman Corp. v. PBGC*, 446 U.S. 359 (1980).

It is equally well established that the costs of providing health care have escalated out of all proportion,[14] and are threatening either to destroy private welfare plans or to force those plans to take drastic measures to remain solvent, including restricting or eliminating a whole range of benefits and terminating coverage for retirees.

In response to the health care problem, both New York and New Jersey enacted hospital rate-setting laws designed to contain the costs of health care within the state and to assure the financial solvency of their hospitals. As Respondents emphasize, New York's law differs from the New Jersey law at issue in *United Wire*, because it seeks to directly influence ERISA plans in the selection

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[14] *See Clinton Administration Description of President's Health Care Reform Plan, American Health Security Act of 1993, dated September 7, 1993*, BNA Special Supplement (September 13, 1993). According to this Report, health care costs are rising faster than other sectors of the economy; will consume about two-thirds of the increase in the Gross Domestic Product ("GDP") for each American for the rest of the decade; and will grow from 14 percent of the GDP to 19 percent without regard to an expansion of coverage to insure all Americans. (S-3.)

of an insurer, *i.e.*, to encourage them to shift from commercial insurers to the Blues. Nevertheless, both statutes share a common feature, in that they are predicated on *base* DRG rates (applicable to hundreds of specific types of treatment) designed to offer hospitals incentive to control costs while compensating them for the direct and indirect costs of providing services. Moreover, both laws contain DRG *surcharges* that are unrelated to the costs of the benefits received by plan participants. The NCCMP challenges only the surcharges [15] as imposing a selective and impermissible burden on self-funded multiemployer plans that directly affects their structure and administration, if not their very existence.

While New York's base DRG rates include a component for bad debts and charity care,[16] the law additionally requires ERISA plans (including self-funded plans) to pay hospitals a 13 percent surcharge or 113 percent of the base DRG rates. Similarly, HMOs are subject to a maximum 9 percent surcharge, depending on how many Medicaid recipients they enroll. However, no surcharge is added to the base DRG rates for patients covered by Medicaid or by a Blue Cross/Blue Shield plan (the "Blues"). As conceded by all Petitioners and their *amici*, a primary purpose of the 13 percent surcharge is to encourage participation in the Blues by making those

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[15] Under the New Jersey law, self-funded ERISA plans were compelled to pay surcharges of up to 37 percent of the base DRG rate, *e.g.*, a 19.1 surcharge to reimburse the hospital for the costs of providing uncompensated care (including bad debts); a 7 percent surcharge to reimburse the hospital for the difference between federal Medicare payments for specific services provided and the DRG rates established for those services (payable by non-Medicare recipients); and a maximum 11 percent surcharge to reimburse the hospital for discounts permitted to certain high volume insurers such as Blue Cross and Blue Shield and to plans having open enrollment. This funding mechanism was amended, effective January 1, 1993, to eliminate the DRG system of rate setting in favor of deregulated market competition.

[16] N.Y. Pub. Health Law, § 2807-c *et seq.* (McKinney 1993).

plans more competitive with commercial insurers, while the purpose of the 9 percent assessment is to encourage HMOs to enroll more Medicaid recipients to lower the costs of the Medicaid program. It is not seriously disputed that the 9 percent surcharge assessed on HMOs will ultimately be passed on to plans in the form of higher rates, which may influence a decision with regard to their continued use.

Given the above, it is clear that this Court may affirm the Second Circuit's opinion without addressing the Third Circuit's decision in *United Wire*, as the facts clearly demonstrate the relation of the New York law to ERISA plans, *infra*. However, if the Court reaches *United Wire*, the NCCMP urges that the decision be rejected for the following reasons.

This Court has repeatedly emphasized that "ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a Section 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect." *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580 (1992) (citations omitted). The issue in this case is therefore whether a state hospital rate-setting law which disproportionately burdens ERISA plans through selectively-imposed surcharges has sufficient "connection with" such plans to trigger ERISA's preemption clause.

The courts below correctly found that New York's DRG surcharges "relate to" ERISA plans within the meaning of this Court's precedents because they not only substantially increase the cost of providing benefits but could actually lead to changes in the way a plan provides benefits or to a reduction or elimination of benefits. Accordingly, the surcharges were held to be preempted by ERISA.

In *United Wire*, the Third Circuit found that the DRG surcharges imposed on ERISA plans were not preempted.

The court reasoned that despite the surcharges, the rate-setting statute was "a generally applicable law" that was not intended to regulate the affairs of ERISA plans; did not single out such plans for special treatment; was not predicated on the existence of ERISA plans; had no effect on the structure or administration of such plans; and—in sum—did not "relate to" ERISA plans.

Although the Third Circuit acknowledged that the surcharges would impose an economic burden on ERISA plans, the court found that "[t]his effect is no different in kind . . . from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, *i.e.*, utility costs, the wages of its employees, waste disposal costs, etc." 995 F.2d at 1193.

Moreover, although New Jersey conceded that its hospital rate-setting law would not be "viable" without ERISA plans, the Third Circuit also concluded that this economic fact did not trigger preemption although the state's concession was tantamount to an admission that the DRG law was designed to selectively and disproportionately burden ERISA plans and would have no meaningful existence without them.[17]

Following the reasoning in *United Wire*, Petitioners and their *amici* urge that ERISA's preemption provision was not intended to insulate employee benefit plans from regulated markets. They therefore argue that unless state health care financing laws (and by analogy other regulatory laws enacted by states under their police powers) directly refer to ERISA plans or indirectly dictate or restrict plan content or administration, the law's economic impact (even if substantial) should be excluded in determining whether the law is preempted.[18]

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[17] *Compare* 995 F.2d at 1192, n.6 *with* dissent at 1199-1200.

[18] *See*, for example, Petitioner Cuomo's Brief, pp. 10-11. In this regard, however, the *amicus* brief of the States of Minnesota *et al.*, suggests a narrower standard; namely, that state laws having an

In support of this position, Petitioner Cuomo, on behalf of the State of New York, argues that "health care assessments, like state regulation of hospital capital improvements, medical waste disposal, minimum hospital staffing requirements, and a whole host of other regulations, increase the cost of providing medical care and, therefore, the cost of health care coverage provided by the plans. As the cost of medical care increases, plans may respond by reducing benefits, but there is nothing in ERISA's language, structure, or legislative history to indicate that ERISA was designed to protect participants from this possibility." *See* Cuomo Brief, p. 11, and similar arguments raised in the other briefs seeking reversal of *Travelers.*

Petitioners and their *amici,* however, overstate the case by confusing the cost of doing business with cost-shifting. As noted earlier, New York's *base* DRG rates (like those of New Jersey) already factored in the operational costs of providing hospital services; indeed, New York's base DRGs include a nondiscriminatory factor related to the cost of providing care for the indigent and uninsured. Clearly, *base* DRG rates applicable to all payers can be arguably justified as part of the cost of doing business in the state. However, DRG *surcharges* which are selectively imposed for reasons unrelated to the cost of the services being provided and which disproportionately burden ERISA plans reflect a cost-shifting mechanism which is qualitatively different from a neutral cost of doing business, such as the cost of waste management. In the NCCMP's view, the DRG surcharges should be preempted —even without regard to their specific economic consequences—because this type of cost-shifting, by definition, directly and blatantly "relates to" ERISA plans.

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indirect but substantial impact on ERISA plans should be preempted only if they treat ERISA plans differentially. *See* Brief, pp. 27-28.

On the other hand, if the cost-shifting effect of New York's DRG surcharges is characterized as an indirect result of a state law of general applicability, Congress's concern with the financial soundness of ERISA plans compels this Court to weigh the economic impact of the surcharges.

Finally, even in the absence of cost-shifting, there is nothing in ERISA, its legislative history, or in this Court's precedents to support the conclusion that the economic impact of a state law, even one of purported general applicability, should be excluded from the preemption analysis merely because the economic impact of the law is alleged to be indirect or because the effects of the law—whether direct or indirect—are solely economic.

With regard specifically to self-funded ERISA plans, the NCCMP disagrees with Petitioners' general proposition that the impact of New York's law is indirect and purely economic. Clearly, the 13 percent surcharge is direct because self-funded plans must pay the surcharge that is added to the hospital bill of each and every participant and beneficiary. If the plan has a significant number of participants in New York, the aggregate cost of the surcharges would likely be substantial. As the courts below clearly recognized, these costs could lead to a reduction or elimination of benefits.

Moreover, the economic impact of both the 13 and 9 percent surcharges could require a change in plan design beyond the reduction or elimination of benefits. As Respondents emphasize, the plan could be compelled to abandon its existing mechanisms for providing health benefits and, solely for reasons of cost, convert to the Blues (a stated goal of the New York law!).[19] To the extent

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[19] While many ERISA plans voluntarily choose to provide coverage through Blue Cross and Blue Shield, trustees of self-funded ERISA plans might have serious concerns if compelled to convert to the Blues, particularly in New York. This Court may take judicial notice that the Blue Cross/Blue Shield—Empire Plan

the plan ceases to provide benefits through an HMO, participants would suffer a disruption in their medical treatment, as HMOs provide medical services and are not merely payers. In addition, since the Blues might not provide a level of benefits satisfactory to participants, or process claims in the manner desired, such a change in plan design could adversely affect subsequent collective bargaining negotiations. To the extent employers bargain out, a multiemployer plan's asset pool, which is generated by employer contributions, would be diminished. Depending on the size of the plan, its very existence could be jeopardized.

C. This Court's preemption analysis should take into account the realities in which self-funded multiemployer plans operate.

The NCCMP believes that selectively-imposed surcharges, and similar cost-shifting statutes, directly affect all ERISA plans and therefore "relate to" these plans in a manner that triggers preemption under ERISA Section 514(a). Moreover, the NCCMP believes that even if a state law has an indirect and/or solely economic impact on an ERISA plan, the economic effect of the law should be included in the preemption analysis.[20]

(New York) has recently been the subject of an intensive investigation by the Senate Committee on Governmental Affairs. *See Oversight of the Insurance Industry: Blue Cross/Blue Shield—Empire Plan (New York): Hearings Before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs United States Senate,* 103rd Cong., 1st Sess. (1993).

[20] The NCCMP also agrees with the courts below, and with Respondents, that the DRG surcharges should not be "saved" as a law regulating insurance. However, in the event this Court finds that the surcharges "relate to" ERISA plans under § 514(a) but are "saved" under § 514(b)(2)(A), the NCCMP requests that the Court clarify that self-funded multiemployer plans are protected from the surcharges by § 514(b)(2)(B), as these plans are not subject to state insurance regulation.

Because of the realities in which self-funded multiemployer plans operate, cost-shifting strategies are particularly harmful to these plans. Therefore, these realities should be taken into account in evaluating the merits of the Second Circuit's approach to preemption.

Multiemployer employee welfare benefit plans are created by the parties to collective bargaining agreements for the purpose of providing health and welfare benefits to workers and their families. In addition, many welfare benefit plans provide sorely needed coverage to retirees.

Most collectively bargained plans are self-funded through the ongoing contributions of several, hundreds, or even thousands of employers in one or more industries involving participants working or living in one, several, or many states. The contributions are pooled for investment to provide benefits to all participants in the plan, and their families. A key feature of multiemployer plans is that participants can move from one contributing employer to another within the plan without losing their benefit rights, making such plans a model for portability. In addition, multiemployer plans—rather than employers—provide COBRA benefits if a worker is terminated or laid off or some other qualifying event occurs even if the employee's employer subsequently bargains out of the plan.[21]

Although self-funded multiemployer plans provide a socially desirable function and have enormous obligations, amounts available to pay benefits are limited by the fact that employer contributions are only one component of an employer's labor costs and, in general, have not been uniformly able to keep pace with spiraling health care costs. As Robert A. Georgine, Chairman of the NCCMP, explained in a letter to the Speaker of the House:

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[21] *See* Sections 601-607 of ERISA, 29 U.S.C. §§ 1161-1167; 26 U.S.C. § 4980 B; and *South Central United Food and Commercial Workers Unions and Employers Health and Welfare Trust v. Appletree Markets*, 19 F.3d 969 (5th Cir. 1994).

> Collectively-bargained employer contributions to multi-employer health plans are part of a covered worker's compensation package for his or her labors. Such contributions are in lieu of cash wages. Workers forego a portion of their wages and wage increases to have their employers contribute to multi-employer health plans. Increases in plan costs caused by taxes and other government-imposed charges divert plan assets away from benefits for the covered workers and their families. Increased plan costs mean increases in the rate of contributions, and declining wages, as a greater portion of the worker's compensation package is allocated to health plan contributions instead of wages.
>
> Our plans are already troubled by the uncontrolled inflation in health care costs and cost-shifting, and covered workers are increasingly faced with benefit cutbacks and wage reductions as a result. The economic recession has exacerbated these troubles, as the lack of work causes declines in plan contribution income and increases in benefit usage.[22]

Far from being a deep pocket, self-funded multiemployer plans have become increasingly threatened, not only by the factors stated above, but by labor unrest precipitated by the rising costs of health care and therefore demands for increased contributions. For example, a three-year study prepared a few years ago by the Service Employees' International Union concluded that the number of strikes over who will pay the rising costs of health care have increased by more than 300 percent since 1986, and that such work stoppages in 1989 alone cost the United States economy more than $1.1 billion in lost wages and productivity.[23] Absent health care reform, there is no

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[22] Letter from Robert A. Georgine to the Honorable Thomas S. Foley, Speaker of the House of Representatives, dated May 21, 1993, urging a national solution to the health care crisis.

[23] *See Labor & Management: On a Collision Course Over Health Care*, 17 Pen. Rep. (BNA) 375 (Feb. 26, 1990).

reason to believe that health benefits will become less important as a mandatory subject of bargaining and therefore as a potential source of labor disputes. Given the relatively fragile nature of multiemployer plans and the environment in which they operate, the "cost of goods and services" analysis of the Third Circuit is particularly inapposite.

Cost-shifting statutes are not only economically threatening to multiemployer plans; they are also inconsistent with fundamental principles of ERISA.

First, trustees have a fiduciary obligation to maintain a sound funding policy. Therefore, although the parties to collective bargaining agreements negotiate the amount of money the employer agrees to dedicate to providing health benefits, it is the trustees of self-funded multiemployer plans who normally have sole discretion and authority—under the governing trust agreement and applicable benefit plan—to determine the type and range of benefits the plan can and will provide and to establish eligibility requirements on the basis of the plan's financial resources and such actuarial considerations as the number and age of participants and previous claims experience. These are sensitive determinations that frequently require the input of the fund's actuarial consultant. *Ad hoc* and selectively-imposed surcharges clearly interfere with the trustees' funding responsibilities and upset the actuarial determinations upon which their decisions are made.

Second, the premise of eligibility for benefits in a self-funded multiemployer plan is coverage under a written collective bargaining agreement.[24] Since Section 404(a) of ERISA, 29 U.S.C. § 1104(a), imposes on trustees the

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[24] Section 302(c)(5) of the Labor Management Relations Act of 1947 ("LMRA"), as amended, 29 U.S.C. § 186(c)(5), prohibits employers from making and employee benefit plans from accepting contributions except pursuant to a detailed written agreement specifying, among other things, the persons on whose behalf the contributions are being made.

fiduciary obligation to act in the sole and exclusive interest of the plan's participants and beneficiaries, fund assets may not be used to pay benefits to individuals other than to employees covered by collective bargaining agreements and their families, except as otherwise permitted by the trust agreement governing the plan.[25]

Finally, Section 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), requires trustees to comply with the terms of the plan's governing documents as long as those documents are consistent with ERISA. Therefore, if the trust agreement does not permit the trustees to extend coverage to individuals who are not covered by a collective bargaining agreement or participation agreement, the trustees breach this fiduciary duty if they provide benefits to such persons.

As a result of the Third Circuit's ruling in *United Wire*, fund trustees have been compelled to act in a manner inconsistent with ERISA's mandates by diverting millions of dollars to pay for the benefits of nonparticipants, as a result of the 19.1 percent surcharge specifically earmarked as a contribution toward uncompensated care. Although the Third Circuit stated that it was "not troubled" by this aspect of the cost-shifting structure of New Jersey's DRG statute, the NCCMP submits that the court of appeals failed to appreciate the requirements of ERISA and the LMRA, mischaracterized the surcharges as the mere cost of doing business in New Jersey, and ruled in a manner that is totally inconsistent with this Court's decision in *Local 144 Nursing Home Pension Fund, et al. v. Demisay*, 113 S.Ct. 2252 (1993).

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[25] While the trust agreements of some multiemployer plans permit trustees to extend coverage to other classes of persons under participation agreements, for example, the employees of the union or the fund or the salaried employees of contributing employers, nothing in federal employee benefits law authorizes trustees to divert fund assets to finance the benefits of individuals who are not covered by any written agreement either with the union or the fund.

For the reasons stated above, the NCCMP submits that relevant federal law compels the preemption of New York's DRG surcharges with respect to self-funded multi-employer plans.

II. JUDICIAL EXEMPTIONS FROM ERISA'S PREEMPTION PROVISION INTRUDE IMPERMISSIBLY UPON AN AREA RESERVED EXCLUSIVELY TO CONGRESS.

In effect, Petitioners and their *amici* request that this Court, by judicial fiat, carve out an exception to preemption for state health care financing statutes on the assumption that Congress did not intend to prevent states from regulating health care costs under their traditional police powers even if such regulation results in the diversion of fund assets to pay for the benefits of nonparticipants. The NCCMP submits that Petitioners' assumption is incorrect. The NCCMP is therefore concerned that unless the Petitioners' reasoning is abandoned and the Second Circuit's opinion is affirmed, other courts of appeals[26] may be encouraged to carve out similar exemptions, not only for state health care financing laws but also for other laws promoting important state objectives,[27]

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[26] In concluding that New Jersey's DRG surcharges were not preempted, the Third Circuit stated that it was "unwilling to attribute to Congress and § 514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged." 995 F.2d at 1196.

[27] It may be recalled that prior to this Court's decision in *FMC Corp. v. Holliday, supra*, the Courts of Appeals for the Third and Sixth Circuits had carved out an exemption from preemption for state no-fault insurance statutes, opining that such statutes should be "saved" because they promoted important state interests without impermissibly intruding on "core" ERISA concerns. *FMC Corp. v. Holliday*, 885 F.2d 79 (3d Cir. 1989); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987). The NCCMP filed an *amicus* brief in *Holliday* because it feared

in derogation of Congress's determination that employee benefit plans should be regulated exclusively by federal law.

The plain language of ERISA Section 514, 29 U.S.C. § 1144, does not support broad-based judicial exemptions from preemption. First, § 514(a) clearly states that ERISA supersedes any and all state laws relating to employee benefit plans (with limited exemptions not relevant here). Nowhere in § 514 is there a legislative exemption for generally applicable state laws that also relate to employee benefit plans, no less for generally applicable state laws regulating health care. Rather, § 514(b)(2)(A) "saves" from preemption only those state laws that regulate insurance, banking, and securities (except as applied to self-insured plans which—under § 514(b)(2)(B)—are deemed not to be engaged in the business of insurance, banking, or securities for purposes of those laws), while § 514(b)(4) exempts generally applicable *criminal* laws from the reach of § 514(a).

Where Congress wished to create an exemption for state health care financing laws, it did so expressly in the statute. Thus, § 514(b)(5)(A) contains an express exemption for the Hawaii Prepaid Health Care Act while §§ 514(b)(5)(B) and (C) contain equally express limitations on the exemption.

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that the "core ERISA concern" standard of preemption would erode the "deemer" clause and "save" a whole variety of state statutes and common law rules regulating insurance, banking and securities, since courts would be likely to differ on what they perceived as "core ERISA concerns." The NCCMP has even greater concerns with regard to the Third Circuit's approach in *United Wire* because, in contrast to *Holliday* which involved the scope of the "deemer" clause, the Third Circuit's interpretation of § 514(a) does not even leave open the possibility of distinguishing between self-funded and insured plans to secure the greater protection which this Court has afforded self-funded plans in *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*, and in *Holliday*.

That state health care financing laws relating to employee benefit plans are clearly preempted by ERISA unless and until *Congress* decides to exempt them is clearly evidenced by a bill which Senator Durenberger introduced in September 1992.[28] That bill, entitled "State Health Care Financing Equity Act of 1992," [29] was intended to waive certain preemption requirements of ERISA by adding two paragraphs (9 and 10) to § 514(b) to exempt from the reach of § 514(a) any qualified state health financing program that imposes a tax, premium, or surcharge on health plans doing business in the state (including self-funded plans) or requires such plans to participate in a risk pool for the medically uninsurable.[30]

The proposed bill expressly provided that states would not be prohibited from setting hospital rates prospectively under a DRG methodology which could include charges for uncompensated care as well as adjustments necessitated by Sections XVIII and XIX of the Social Security Act. However, states would have to apply for an ERISA waiver, and federal review and oversight was intended to be both comprehensive and pervasive, *inter alia*, to assure that the state law would be capable of fulfilling its goals and would also be nondiscriminatory.

In addition, four states (Hawaii, New York, Maryland, and Minnesota) applied for individual waivers from

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[28] S. 3223, 102nd Cong., 2nd Sess. (1992), 138 Cong. Rec. S13267-02.

[29] The bill was divided into two major sections, captioned "Waiver of ERISA Preemption for State Universal Health Plans" and "State Provider Taxes and Prospective Payment Systems."

[30] At the time the bill was submitted, 26 states had established risk pools to insure the medically uninsurable by assessing taxes and premiums on insurers, and other states were developing similar programs to provide broad-based access to health care to be financed by similar taxes or premiums. In addition, 22 states imposed taxes on hospitals, doctors, and other providers to finance uncompensated health care.

ERISA preemption—as part of the proposed Omnibus Budget Reconciliation Act of 1993—to allow them to regulate hospital rates and to permit them to recover the cost of providing indigent care by imposing surcharges and by increasing costs for health plan participants (including participants in self-funded plans).

Although the above proposals have not yet become law, it is clear that if exemptions from ERISA preemption are to be made for state health care financing statutes, pending national health care reform, the exemptions must be made by Congress and not by the courts, which are neither equipped nor authorized to solicit, process, or debate the type of broad-based information that must necessarily be considered and balanced in the course of amending a complex federal statute of great national scope, such as ERISA.

Pending federal legislation, however, the NCCMP requests this Court to reject Petitioners' "cost of doing business" standard, to adopt a preemption standard that will require courts to invalidate state laws imposing selective and differential burdens on ERISA plans, such as New York's DRG surcharges, and to clarify that economic considerations may justify preemption even if a state law is facially neutral.

CONCLUSION

For the reasons stated above, the NCCMP respectfully requests this Court to affirm the decision below and to rule that New York's DRG surcharges are preempted, at least with respect to self-funded ERISA plans.

Respectfully submitted,

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO CUOMO, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioner

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

This brief of Group Health Association of America, Inc. ("GHAA"), as *amicus curiae,* is filed in support of respondents and in favor of affirmance of the ruling of the United States Court of Appeals for the Second Circuit on the preemption questions presented under the Employee Retirement Income Security Act of 1974,

as amended ("ERISA"). GHAA submits this brief with the written consent of the parties, as provided in Rule 37.3 of the Rules of this Court.

INTEREST OF AMICUS CURIAE

The Group Health Association of America, Inc., founded in 1959, is the oldest and largest national association for health maintenance organizations ("HMOs"). GHAA has more than 375 HMO member plans nationwide. Together, these members enroll about 40 million people. More than 50 million Americans, one-fifth of the total population of the United States, receive their health care coverage through HMOs.

HMOs provide integrated, coordinated, high-quality health care coverage, with an emphasis on preventive care, at predictable and affordable costs to consumers. HMO members are highly satisfied, and HMOs have received high enrollment renewal rates. For these reasons, many employers, including multi-state employers, offer benefit plans using the HMO approach to health care delivery.

GHAA has a strong interest in the ERISA preemption questions presented by this case because permitting the states to regulate through laws that interfere with the design and structure of employee benefit plans offering HMO coverage would severely compromise the ability of HMO plans to maintain the cost efficiencies they have achieved. HMOs' ability to provide more affordable, comprehensive coverage and to limit out-of-pocket costs has significantly reduced the financial barriers to accessible health care that exist with other forms of health care coverage. This enables HMOs to emphasize a philosophy of prevention, which means that HMO members are able to seek care for small health problems before they become serious ones. If allowed to stand, the states' disparate economic treatment of HMOs will undermine the ability of employers, and ultimately their employees, to choose the HMO

approach – the most cost-efficient system of health care available today.

The State of New York, through the imposition of a 9% assessment on the cost of inpatient hospitalization services to HMO plans, has severely limited the efficiencies HMO plans have achieved through a comprehensive system of benefits and preventive care. The effect of the State's assessment is to disrupt the benefits of a high quality, cost-efficient HMO plan sought by employers with employees in New York. The Second Circuit's conclusion that New York's 9% assessment is preempted by ERISA because it "relates to" ERISA plans that select HMO coverage protects HMO plans from such interference by the states. It further ensures that employers who offer such plans will not be subject to a differing scheme of regulation across the states in which they have employees.

SUMMARY OF ARGUMENT

With increasing frequency, sponsors of employee health benefit plans are choosing to structure their plans around the cost competitiveness of HMOs, seeking the benefits of a high quality, coordinated care system both for the participants in the plan and the sponsors themselves. The HMO option provides employee benefit plans with quality health care coverage and comprehensive benefits at an affordable price.

In response to the historical obstacles to the development of HMOs imposed by the states, Congress established a federal policy, through the enactment of the Federal Health Maintenance Organization Act, to shield HMOs from unfair treatment. This federal law has provided HMOs with the necessary protection to develop and flourish without state interference.

The Federal HMO Act was enacted in 1973, one year before Congress passed ERISA, another federal law intended to protect employee benefit plans from state interference. ERISA's expansive preemption clause has

been interpreted by this Court to prevent the states from interfering with the operation and structure of ERISA health benefit plans and from disrupting the uniform federal regulation of such plans.

New York's 9% assessment singles out HMO plans for disparate economic treatment. The impact of the assessment on HMO plans is direct and substantial because it forces plans either to raise costs by a factor of up to 3.5% or to reduce benefit levels, or some combination of the two. Moreover, by singling out HMOs to the exclusion of other health care delivery systems, the 9% assessment disrupts the balance of incentives established when plan sponsors emphasize HMO coverage over more costly indemnity insurance. Such disruption intrudes upon the structure of ERISA benefit plans. ERISA prohibits such disruption to the design and administration of employee benefit plans by the states, particularly where, as here, the disruption is targeted at one particular form of health care delivery system.

In construing ERISA's preemption clause, this Court has turned to federal policy as a guide to Congress' intent in removing employee benefit plans from the realm of state regulation. Finding that the 9% assessment interferes with the choices made by employee benefit plans in providing health care coverage to their members is consistent with the purpose of the Federal HMO Act – to prevent the states, which traditionally have favored indemnity insurance, from singling out HMOs through disparate regulation.

For these reasons, the Second Circuit's decision finding that the 9% assessment is preempted because it "relates to" ERISA plans should be affirmed.

ARGUMENT

I. THE DEVELOPMENT AND GROWTH OF THE HMO CONCEPT OF COORDINATED CARE IN THE UNITED STATES.

A. THE HMO ALTERNATIVE AND THE FEDERAL POLICY PROTECTING IT.

Fifty years ago, the concept of prepaid health care coverage was a novelty. HMOs historically have faced difficulty in entering and competing in health care markets dominated by health plans and insurers operating on an indemnity basis and have struggled with the long-ingrained hostility to prepaid, closed-panel medical practice among segments of the medical community. *See, e.g., American Medical Ass'n v. United States,* 317 U.S. 519 (1943); *American Medical Ass'n,* 94 F.T.C. 701 (1979), *aff'd as modified,* 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam,* 455 U.S. 676 (1982).

In 1973, Congress took steps to remove impediments to the development and growth of HMOs by enacting the Federal Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e, *et seq.* (1987). Some of the Act's provisions created authorizations for appropriations for HMO feasibility, planning and development, and others barred the states from restricting HMO activities through legislation.

The Congressional findings that resulted in the HMO Act include "substantial evidence" to establish that HMOs provide high quality care to their members at a lower cost — as much as one-fourth to one-third lower than traditional care. S. Rep. No. 93-129, 93d Cong., 1st Sess., *reprinted in* 1973 U.S.C.C.A.N. 3033, 3034. Thus, in order to permit HMOs to continue their growth and development, and to continue to fill their niche in the national health care system, Congress enacted a federal law protecting HMOs from interference by the states:

> First, and most important, the development of HMOs throughout the country will provide consumers with the opportunity to choose the manner in which they will pay for and receive health care services. At the present time, no such choice exists in most parts of the United States. Therefore, in excess of 95% of all health services are rendered on a fee-for-service basis. The goal of this legislation is to increase the options from the point of view of the consumer.

Id., at 3039-40.

Since the enactment of ERISA, Congress has amended the Federal HMO Act several times. The amendments extended the authorizations for appropriations for HMO feasibility, planning and development, and provided HMOs flexibility in meeting consumer needs. In passing the 1978 amendments, Health Maintenance Organization Amendments of 1978, P.L. 95-559, 92 Stat. 2131 (codified as amended at 42 U.S.C. §§ 300e, *et seq.* (1987)), Congress expressly emphasized the important role played by the reforms generated by the HMO delivery system, particularly in terms of their cost efficiency:

> Few health care delivery reforms enjoy the deep support and broad appeal of the Health Maintenance Organization concept. One of the major advantages of HMOs is their cost containment potential. The skyrocketing cost of health care is one of the most pressing issues facing the nation today. While HMOs are not the final answer to the health care cost problem they do give providers strong incentives to reduce unnecessary expenditures; and they create much-needed competition for the health care dollar.

S. Rep. No. 95-837, 95th Cong., 2d Sess. 8, *reprinted* in 1978 U.S.C.C.A.N. 4925, 4942.[1]

The 1987 amendments provided greater flexibility in the way HMOs are organized and operated. Health Maintenance Organization Amendments of 1987, P.L. 100-517, 102 Stat. 2578 (codified as amended at 42 U.S.C. §§ 300e, *et seq.* (1987)). In enacting these amendments, Congress again emphasized the important role that HMO plans play in American health care delivery systems:

> The HMO law has proven to be one of our most important public health statutes. . . . The law has helped to develop hundreds of prepaid health care organizations that have changed the face of medical care in this country. *HMOs have successfully controlled health care costs and, by their very presence, forced other providers and insurers to become more efficient and less costly.*

S. Rep. No. 100-304, 100th Cong., 2d Sess. 8, *reprinted in* 1988 U.S.C.C.A.N. 3231, 3232 (emphasis added).

When the Federal HMO Act was passed, there were only 39 prepaid health care plans in existence in the

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1. As part of the 1978 amendments, Congress specifically acted to abrogate certain state practices that were designed to interfere with the operation of HMOs while simultaneously favoring indemnity insurance. Under then existing provisions of the law, HMOs were required to meet state certificate-of-need requirements relating to the provision of basic health services to members. However, state agencies were employing unobjective appraisals for HMOs' certificates because HMOs competed with indemnity insurers, which frequently were given objective appraisals or were not required to file certification-of-need applications at all. S. Rep. No. 95-837, 95th Cong., 2d Sess. 13, *reprinted in* 1978 U.S.C.C.A.N. 4925, 4947-48. In order to further HMOs' "exceptional capacity to serve the overall goals of the planning process when allowed to operate properly," Congress amended the Federal HMO Act to establish more objective certificate-of-need standards that would be subject to less interpretation and variation at the state level. 42 U.S.C. § 300e(b)(4), (5) (1987).

United States, serving approximately 3.5 million enrollees. A mere five years later, the number of prepaid health care plans had increased five-fold to 198 plans, serving 7.3 million enrollees in 37 states. Interstudy, *National HMO Census: June 30, 1983,* 38-39 (1984); U.S. Department of Health, Education and Welfare, Public Health Service, Office of Health Maintenance Organizations, *National HMO Census of Prepaid Plans,* 1 (1978). This dramatic increase in the number of HMOs and the consumers served is perhaps the best evidence that the Federal HMO Act has been effective in achieving Congress' goal of encouraging the growth and development of HMOs.

B. THE HMO TODAY.

The HMO industry has continued to grow tremendously. Over the past 14 years, the number of people cared for by HMOs has grown more than five-fold to 50.5 million, up from 9.1 million people in 1982. GHAA, *National Directory of HMOs,* 22 (1993); GHAA, *1994 HMO Performance Report,* 3 (1994). A large proportion of American employers offer HMO coverage, and their employees are selecting HMO coverage at an increasing rate. By year-end 1995, 56 million Americans are expected to have selected HMOs for their health care coverage. GHAA, *1994 HMO Performance Report,* 1 (1994).

HMOs provide or arrange for the provision of health care services to their members in various ways. Some employ staff physicians. Some contract with individual physicians as independent contractors. Others contract with medical group practices or with associations of individually practicing physicians. Some HMOs may use a combination of these methods. However, all HMOs, by whatever method adopted, provide or arrange for the provision of health care services to members through integrated networks of select health care providers.

HMOs offer comprehensive coverage, including preventive care, on a prepaid basis. In contrast, traditional indemnity health benefit plans generally indemnify policyholders only for designated, medically-necessary health care services without regard to the provider of those services.

Covered basic health services under an HMO plan generally include physician services and referral services to specialists, inpatient and outpatient hospitalization, emergency care, diagnostic laboratory and therapeutic radiologic services, inpatient and outpatient rehabilitation services, recuperative therapy services (e.g., physical, occupational and speech), outpatient mental health services, detoxification services and referrals for addiction and home health care. Most HMOs also provide coverage for prescription drugs. *See, e.g.*, 42 U.S.C. §§ 300e-1(1) (1987) (basic health services for federally qualified HMOs); *see also* GHAA, *HMO Industry Profile: 1994 Edition*, 3-7 (1994). HMOs also provide preventive care coverage, including immunizations, well-child care from birth, periodic health evaluations for adults, voluntary family planning services, infertility services and children's eye and ear examinations. *See, e.g.*, 42 U.S.C. § 300e-1(1)(H) (1987) (preventive health services for federally qualified HMOs). As a rule, HMOs cover more services than indemnity insurance plans, typically with no deductibles and with minimal, if any, co-payments.

HMO coverage also is more comprehensive than indemnity insurance coverage in financial terms. For example, HMOs impose no lifetime limits on benefit coverage, and they cover pre-existing conditions with no waiting period. 42 U.S.C. § 300e(b) (1987) (HMO basic health services must be provided without limitation as to time or cost). Indemnity insurance coverage, in contrast, typically has a lifetime cap of $1 million and imposes a waiting period for coverage of pre-existing conditions.

HMOs set high standards for quality assurance and consumer satisfaction. HMOs promote health care quality in many ways, including careful selection of providers based on professional qualifications and interest in working within a coordinated care system. GHAA's most recent survey revealed that 85% of all HMO physicians are board certified. According to the latest data from the American Medical Association, only 61% of practicing physicians nationwide are board certified. GHAA, *1994 HMO Performance Report,* 11-12 (1994).

In addition, HMOs have quality assurance and improvement programs that are not available through indemnity insurance. HMOs utilize state-of-the-art practice guidelines and standards developed by independent accreditation organizations (*e.g.,* National Committee for Quality Assurance), monitor quality-of-care indicators and outcomes, identify and pursue areas for necessary improvements and measure improvements in performance over time. HMOs make available to the physicians and medical professionals who participate in their networks information regarding member referrals to participating specialists and medical facilities. HMOs also provide participating physicians and medical professionals with practice standards and utilization management data to ensure that patients receive medically necessary and appropriate care. These programs and sources of information enable HMOs to provide the employer-sponsor of an HMO plan with quality, effective and efficient health care for their employees.

The explosive growth of HMO plans is due in large part to the fact that employers have experienced annual premium increases averaging 13.4% for traditional indemnity health plans in recent years. KPMG Peat Marwick, *Trends in Health Insurance: HMOs Experience Lower Rates of Increase than Other Plans,* 4 (1993). Faced with the untenable choices of reducing contributions to the cost of employee health coverage or imposing new coverage limitations, adding or raising deductibles and coinsurance, reducing the benefits covered or

eliminating health coverage altogether, plan sponsors understandably have turned to HMOs as a more affordable means of providing comprehensive health care coverage to their employees.

It is these unique characteristics of quality assurance, comprehensive benefits and affordability that distinguish HMO plans from other health care coverage options, including indemnity insurance. Moreover, as a result of these attributes, HMOs bring cost efficiency to the health care market. In 1992, the cost of traditional indemnity plans averaged $4,080 per employee, 23.2% more than the average cost of HMOs ($3,313 per employee). A. Foster Higgins, *Health Care Benefits Survey: Report 1 Medical Plans,* 12-13 (1992). This cost differential does not take into account the greater differential that would result if the indemnity plans offered the same comprehensive level of benefits that HMOs offer. *See* U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Establishments, 1991,* Bulletin 2422, 38-39 (May 1993) (most indemnity plan participants face average annual deductibles of approximately $200 and coinsurance rates of 20% for all basic services).

Simply stated, HMOs are typically the best value for health care coverage. HMO coverage is especially attractive to a multi-state employer because such coverage offers comprehensive benefits to its employees while simultaneously ensuring the employer that its employees have a coordinated system of health care coverage which is subject to quality assurance review – often at the lowest priced option for health care coverage.

The HMO approach – comprehensive benefits, preventive care coverage, continuity of service and quality assurance, all of which result in significant cost savings – has elevated HMOs to a singularly unique status in America's health care coverage system.

II. ERISA PROHIBITS THE STATES FROM INTERFERING WITH EMPLOYEE HEALTH PLANS THROUGH REGULATION WHICH SINGLES OUT HMO PLANS FOR DISPARATE ECONOMIC TREATMENT.

In 1992, the State of New York imposed a 9% assessment on the cost of inpatient hospitalization paid by HMOs. The assessment bears no relation to the actual cost of services provided to HMO members; rather, it is assessed by the State on the aggregate monthly cost of inpatient hospitalization. With the exception of HMOs, no other type of carrier or provider of health care services in the State of New York must pay the 9% assessment. N.Y. Pub. Health Law §§ 2807-c(2)(a) through (e) (McKinney 1993).

The State adopted the 9% assessment for the primary purpose of encouraging HMOs to enroll Medicaid eligible recipients. The State acknowledges that the 9% assessment is intended as a direct economic penalty for those HMOs that fail to meet the State's target enrollment levels of Medicaid eligible recipients. JA 156. The secondary purpose of the assessment is to raise revenue for the State. Notably, the funds paid by HMOs under the 9% assessment are deposited in the State's general fund and are not specifically earmarked to provide health care coverage to the medically uninsured or underserved.

The 9% assessment interferes with the structure and interstate operation of ERISA health benefit plans that select HMO coverage, thereby establishing the requisite "connection with" such plans for purposes of triggering ERISA preemption. With limited exceptions, ERISA preempts any and all state laws that "relate to" employee benefit plans. 29 U.S.C. § 1144(a) (1985). The clear intent of ERISA's preemption clause, as recognized by this Court, is to

> ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was

> to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies would work to the detriment of plan beneficiaries.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 134 (1990).[2] ERISA, therefore, preempts any state law that has a "'connection with or reference to'" ERISA plans. *Id.*, 498 U.S. at 139, *quoting Shaw*, 463 U.S. at 96-97.

The Second Circuit, in striking down New York's 9% assessment on HMOs, ruled that the assessment "relates to" ERISA plans because it "purposely interferes with the choices that ERISA plans make for health care coverage." *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 719 (2d Cir. 1994). The court reasoned that the 9% assessment interferes with plan design by forcing ERISA plans either to increase the cost of benefits or to reduce the level of benefits available to participants. *Id.*, 14 F.3d at 720.

Other circuit courts have recognized that state legislation which increases the costs of health benefits coverage disrupts the structure of ERISA plans. *See, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hosp. Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991), *cert. denied*, ___ U.S. ___, 112 S. Ct. 2305 (1992) (state law affecting insurer's costs has impact on benefit structure); *cf. General Elec. Co. v. Department of Labor*, 891 F.2d 25, 29 (2d Cir. 1989), *cert. denied*, 496 U.S. 912 (1990)

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2. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1986) (state severance pay statute preempted to alleviate burden on employers' administration of benefit plans); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 105 n.25(1983) (state disability law burdening administration of nationwide plan preempted); *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) (ERISA preempts state law prohibiting offset of workers' compensation payments against pension benefits because it would burden employer plans with conflicting regulatory schemes).

(state law regulating payment of benefits preempted because private parties, not states, control level of benefits).

The 9% assessment has a substantial impact on ERISA plans that select HMO coverage. As a direct result of the 9% assessment on the cost of inpatient hospital services, it is estimated that the cost of HMO coverage in New York has increased by a factor of up to 3.5%. JA-265. Because HMOs must maintain reserves for unexpected medical expenses, this increase in costs must be passed on to the ERISA plans that have selected HMO coverage. JA-262, 265-66. Thus, the 9% assessment, in reality, functions as an assessment on the ERISA plans themselves.

When faced with an increase in the costs of health care coverage, an HMO plan has two options: pay the increase or reduce benefit levels. To absorb the cost increase without reducing benefit levels, HMO plans must raise the premiums that employees pay and/or increase employee cost-sharing through higher co-payments or deductibles. However, the payment of higher premiums and the addition of greater cost-sharing provisions embody the precise afflictions that the plan sponsor sought to avoid by selecting HMO coverage over indemnity insurance. The other option, reducing benefit levels, is equally offensive insofar as it also involves a departure from the HMO concept of providing comprehensive benefits and preventive care coverage. Most significant, however, is the fact that either option has the same result – the ERISA plan is forced to modify its structure and way of doing business.

In the face of these facts, it is undisputed that the 9% assessment and its attendant cost increase to HMO plans affect the administration and design of ERISA health benefit plans that offer HMO coverage. Petitioners Mario M. Cuomo, *et al.*, acknowledge that "[t]he health care assessments may influence plan content or administration because they do not affect all payors equally. State regulation does not affect every aspect of

plan administration or benefits identically and, therefore, a wide range of state regulation may influence ERISA plan activity." Brief for Petitioners Mario M. Cuomo, *et al.*, at 11. Similarly, the AFL-CIO, as *amicus curiae* in support of petitioners, recognizes the impact of the assessments on plan administration and design: "Multi-state ERISA health plans must take these market differences from state to state into account in determining what kind of payment system to adopt or maintain." Brief for the American Federation of State County and Municipal Employees, AFL-CIO as *Amicus Curiae* in Support of Petitioners, at 14.

Petitioners attempt to minimize the assessment's effect as merely an indirect economic impact. Their arguments, however, ignore the fact that economics are inextricably linked to plan choices.[3] In addition, the characterization of the New York assessment law, on the whole, as the "indirect" regulation of health care plans is misleading in the specific context of the 9% assessment. As a preliminary matter, it is well settled that the singling out of ERISA plans through state action runs afoul of the preemption clause, regardless whether the impact is indirect or direct. *See Ingersoll-Rand*, 498 U.S. at 139 ("state law may 'relate to' a benefit plan . . . even if the law is not specifically designed to affect such plans, or the effect is only indirect"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1986), *quoting Shaw*, 463 U.S. at 98 ("preemption clause is not limited to 'state laws specifically designed to affect employee benefit plans'"); *Alessi*, 451 U.S. at 525 ("even indirect state

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3. The important role played by economics in the design and structure of employee benefits has become even more evident from the reductions in employer sponsored benefits in recent years, many of which have resulted in the proliferation of costly and protracted litigation, such as that involving retiree health coverage. Moreover, the recent efforts to develop a national health care system and the debate that ensued over how such a program would be funded reinforced the importance of the role that costs play in defining the structure of health care benefit plans.

action bearing on private pension plans may encroach upon the area of exclusive federal concern").

Moreover, the impact of the 9% assessment on ERISA plans that select HMO coverage is "direct" because the assessment specifically is directed only at HMOs. This is not a law of general application, such as a utility rate or sales tax, which impacts equally all health care delivery systems. It is an assessment that, by its terms, singles out HMOs. Though the impact of a law of general application on one form of health care delivery system might be characterized as "indirect," the impact of a law premised on the disparate treatment of one health care delivery system, to the exclusion of others, such as the 9% assessment, is hardly indirect. It is directed at the cost of HMO coverage, and, therefore, its impact on HMO plans clearly is direct.[4]

Federal policy has been used by the Court as a touchstone to interpret the preemptive scope of ERISA. In *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1987), this Court held that a Georgia garnishment statute was not preempted by ERISA because, based on the statements of federal policy in ERISA's civil enforcement provisions and the "sue and be sued" clauses of other federal statutes, the Court concluded that Congress did not intend to preempt the state garnishment law. In discerning Congress' intent, the Court concluded that the Georgia law withstood the preemption challenge because it was consistent with these sources of federal policy. *Mackey*, 486 U.S. at 831-34 & n.9.

Applying the *Mackey* approach to New York's 9% assessment, it is clear that federal policy does not favor state interference with the competitive market choices of ERISA plans for health coverage. Just one year before

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4. If truly a law of general application, such as a state sales tax, the 9% assessment would affect equally all ERISA health care plans, regardless of their choice of delivery system. Thus, a state sales tax is not preempted by ERISA.

enacting ERISA in 1974, Congress passed the Federal HMO Act of 1973, 42 U.S.C. §§ 300e, *et seq.* (1987), declaring its intent that the states cease interfering with the development of HMOs as a desirable alternative to costly indemnity insurance in the health care coverage market. The Federal HMO Act is a pertinent source of federal policy that must be considered in determing the scope of the ERISA preemption of state laws regulating the health care coverage market for ERISA plans.

Cognizant of the historical treatment of HMOs by the states, Congress enacted a federal law designed to shield HMOs from unfair treatment by the states and to enable HMOs to develop and grow as an alternative to indemnity insurance. The federal policy reflected in the Federal HMO Act leaves little room for doubt that Congress recognized that state action directed at HMOs can have a detrimental and adverse impact on the competitive health care coverage market to which many ERISA plans look for the cost-effective coverage offered by HMOs. To read ERISA's preemption clause so narrowly to exclude state laws specifically directed at HMOs and intended to have an adverse economic impact on them would ignore entirely the federal policy contained in the HMO Act.

ERISA was intended to ensure that the employer's choice of delivery of a uniform health care coverage system across state lines would not be disrupted. 20 Cong. Rec. 29197 (1974) (remarks of Rep. Dent) (ERISA sponsors designed preemption clause to eliminate threat of inconsistent state and local regulations); *id.*, at 29933 (remarks of Sen. Williams) (same); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans . . . ."); *Fort Halifax*, 482 U.S. at 11 (patchwork scheme of state regulation of ERISA benefit plans would introduce considerable inefficiencies in benefit program operation).

The economic impact of the 9% assessment has the effect, contrary to the intent of ERISA, of disrupting the uniform choices of plans sponsored by multi-state employers to provide health care coverage to their employees. When the states are permitted to engage in disparate economic treatment of one form of health care delivery system, as New York has done to HMOs under the 9% assessment, it affects the balance of incentives established by multi-state employers and interferes with the structure of the ERISA plan premised on that balance. Accordingly, the assessment interferes with the ability of multi-state employers to offer uniform health coverage to their employees, including the HMO plan.

The HMO approach is unique because HMOs provide high quality, comprehensive and preventive health care coverage at an affordable price. Indeed, HMO coverage frequently will be the lowest priced option for health care coverage. Thus, HMO coverage is attractive to a multi-state employer that sponsors a health care plan for its employees because such coverage offers comprehensive benefits to employees while simultaneously providing the employer with a health care delivery system that coordinates the care through a network of physicians, emphasizes the prevention of serious health problems, oversees appropriate standards of care and monitors the quality of the services rendered. Only an HMO offers this unique combination of features and benefits in one health care delivery system.

The multi-state employer relies upon the competitive price of HMO coverage, as compared to more costly indemnity insurance, to attract participants to the HMO plans offered in each state where employees are located. Moreover, where the employer uses its lowest-priced health care option, often an HMO, as the benchmark for its contribution to the cost of employee health care coverage, an employee's incentive to select HMO coverage is further enhanced insofar as it is the only health care option that will be fully paid by the employer. This incentive is reinforced because virtually all HMO plans

have no deductibles and nominal, if any, co-payments for covered services. In short, the more attractive the HMO plan is to employees, the more likely it is that they will select the HMO plan for their health coverage.

When employees select HMO coverage over more costly indemnity insurance, the multi-state employer sponsoring the plans also obtains the sought-after benefits of HMO coverage. The employer is the beneficiary of the HMO's philosophy of prevention and quality assurance mechanisms, which are superior to those available under indemnity insurance. The employer knows that its employees are receiving care through a coordinated network of medical professionals, that the quality of the care will be enhanced by the application of practice guidelines and standards and that the care will be subject to ongoing monitoring and improvement. Most significantly, the HMO coverage offers employees comprehensive benefits, including preventive services. All of these aspects of HMO care have the effect of lowering the overall cost of health care coverage while providing enhanced quality.

The 9% assessment disrupts this careful balance of incentives established by the employer sponsoring the HMO plan by appropriating the cost efficiency of HMO coverage. Such legislation erodes the cost effectiveness of the HMO plan, thereby frustrating the incentive that the multi-state employer established to encourage its employees, regardless of the state where they work, to enroll in the HMO. The loss of this incentive, in turn, reduces the likelihood that the employer will realize the benefits of the HMO plan, including the quality assurance and improvement mechanisms that are available only under that plan. Thus, the multi-state employer is deprived of the full pricing incentive to encourage HMO enrollment and of the benefits that flow from its choice to exercise that incentive.

When the states pass legislation that has the direct effect of appropriating the cost effectiveness of an HMO plan, they undermine both the incentive chosen by the

plan sponsor to encourage employee enrollment in the plan and the resulting benefits that flow from that choice – a comprehensive level of high quality benefits. If such laws are not preempted, the states would be free to divest dollar by dollar the choices made by plan sponsors to offer HMO coverage. ERISA, however, is intended to prevent the states from disrupting the design and structure of ERISA plans. The 9% assessment has just such a disruptive effect, and, therefore, it is has a "connection with" ERISA plans. For these reasons, the Second Circuit correctly held that the 9% assessment is preempted.[5]

5. Petitioners do not assert that the 9% assessment is a law regulating the business of insurance that is saved from preemption under ERISA's "insurance savings" clause, 29 U.S.C. § 1144(b)(2)(A) (1985). *See also* Brief of the United States as *Amicus Curiae* Supporting Petitioners, at 19 n.8 (no party argues that the 9% assessment is saved as a law regulating insurance). GHAA concurs that the 9% law is not saved from preemption.

CONCLUSION

For the foregoing reasons, the decision and judgment of the United States Court of Appeals for the Second Circuit in this case should be affirmed.

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Nos. 93-1408, 93-1414 and 93-1415

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*

MARIO M. CUOMO, GOVERNOR OF NEW YORK, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE COMPANY, *et al.*

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner

v.

TRAVELERS INSURANCE COMPANY, *et al.*

On Writs of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE NATIONAL CARRIERS' CONFERENCE COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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ISSUE PRESENTED

We devote this brief to an issue upon which the Court granted *certiorari* but that neither petitioners nor the United States as *amicus curiae* have briefed. That issue is whether New York's 13% surcharge upon all hospital bills paid by, *inter alia*, self-insured plans and plans insured by commercial insurers, but not upon bills paid by plans insured by the Blues, is preempted by § 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), as to self-insured ERISA plans, as distinct from commercially insured ERISA plans.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

No. 93-1408

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,

Petitioners

v.

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No. 93-1414

MARIO M. CUOMO, GOVERNOR OF NEW YORK, *et al.*,

Petitioners

v.

TRAVELERS INSURANCE COMPANY, *et al.*

No. 93-1415

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner

v.

TRAVELERS INSURANCE COMPANY, *et al.*

On Writs of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF OF THE NATIONAL CARRIERS' CONFERENCE COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

STATEMENT OF INTEREST

The National Carriers' Conference Committee ("NCCC") submits this brief as *amicus curiae* urging affirmance of the decision of the court of appeals. Pursuant to Rule 37.3 of the Rules of this Court, the NCCC has filed with the Clerk the written consents of all of the parties in this case to the submission of this *amicus curiae* brief.

The NCCC, consisting of labor relations officials of ten of the nation's major freight railroads and the Chairman of the National Railway Labor Conference, is the sole governing body of fiduciaries for The Railroad Employees National Early Retirement Major Medical Benefit Plan. In addition, along with the Health and Welfare Committee of Cooperating Railway Labor Organizations, the NCCC serves as the governing body of fiduciaries for The Railroad Employees National Health and Welfare Plan. These Plans (the "Railroad Plans" or the "Plans") were established and are maintained pursuant to national collective bargaining agreements under the Railway Labor Act between most of the Class I line haul rail carriers in the United States and the principal twelve railway labor organizations. The Plans are self-insured employee welfare benefit plans under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). They provide health care benefits, including coverage for inpatient hospital care, to more than a half million railroad employees, retirees, and their dependents throughout the country. Respondent The Travelers Insurance Company ("Travelers") provides claims administrative services to the Railroad Plans and acts as a fiduciary of the Plans under §§ 3(21)(A) and 503(2) of ERISA, 29 U.S.C. §§ 1002(21)(A) and 1133(2).

In this case, the court of appeals affirmed the summary judgment of the district court that ERISA preempts the imposition of, among other things, a 13% surcharge under § 2807-c(1)(b) of the N.Y. Pub. Health Law on general hospital bills for inpatient care paid by ERISA-

covered plans, whether such plans are self-insured by the employers maintaining them or insured under a policy issued by a commercial insurer. Reversal of the court of appeals' decision would require the Railroad Plans either (a) to pay the 13% surcharge—approximately $1 million per year—so as to remain self-insured on a national basis as called for by the collective bargaining agreements pursuant to which the Plans are maintained and to continue to have the Plans administered on a national or regional basis by administrators of their choice, or (b) to avoid the 13% surcharge by becoming insured with Blue Cross/Blue Shield (the "Blues") in New York, thus destroying the interstate uniformity of the Plans' structure (self-insured) and administration (nationwide or regional) and subjecting the Plans to New York's host of insurance laws and regulations.

The interest of the NCCC, as fiduciaries of the Plans, is to escape this Hobson's choice.

SUMMARY OF ARGUMENT

I. This case presents two closely related questions: Does ERISA preempt New York's 13% surcharge on hospital bills for inpatient care as the surcharge is applied to ERISA-covered plans that are (a) insured by commercial insurers or (b) self-insured. We contend, contrary to the suggestion of the United States, that the question of ERISA preemption of the surcharge as applied to self-insured plans is properly before the Court and that sound judicial policy calls for its resolution in this case.

The issue of whether ERISA preempts application of the surcharge to self-insured plans has been raised, argued before and decided by both the district court and the court of appeals. Plaintiffs, acting as claims fiduciaries for self-insured plans, raised the issue in their complaints and motions for summary judgment. The district court granted summary judgment in plaintiffs' favor in all respects as to the 13% surcharge, and the court's opinion shows that

the judgment included a declaration that ERISA preempted the surcharge as applied to self-insured plans. Indeed, following the entry of a stay of its judgment on the 13% surcharge pending appeal, the district court ordered the plaintiffs who are claims fiduciaries for self-insured plans to pay the surcharge on their behalf.

Appellants brought the issue regarding self-insured plans to the court of appeals both in their statements of questions presented and in their briefs. In fact, appellant Hospital Association of New York ("HANYS") unsuccessfully opposed the motion of this *amicus* for leave to file a brief in the court of appeals on the ground that the appellees who are claims fiduciaries for self-insured ERISA plans had adequately represented the interests of those plans. The court of appeals affirmed the district court's ruling as to the 13% surcharge in all respects. That the court's opinion did not distinguish between insured and self-insured plans is without consequence, since its ruling found preemption as to both.

All of the petitioners in this Court based their argument for *certiorari* on an alleged conflict between the decision below and the decision of the Third Circuit Court of Appeals in *United Wire, Metal and Machine Health and Welfare Fund* v. *Morristown Memorial Hospital,* 995 F.2d 1179 (3d Cir.), *cert. denied,* 114 S. Ct. 382 (1993), where *only* self-insured plans and their participants challenged various New Jersey hospital rate laws on ERISA preemption grounds. Indeed, the *certiorari* petition of HANYS explicitly framed the issue in terms of whether ERISA preempted New York's different "set of [hospital] rates for patients covered by[, among others,] self-insured plans." Brief for Petitioner HANYS on Writ of *Certiorari* to the United States Court of Appeals for the Second Circuit at (i); *HANYS* v. *Travelers Ins. Co.,* Dkt. No. 93-1415, 63 U.S.L.W. 3282, 3291 (U.S. Oct. 7, 1994).

This Court should decide the issue of preemption as to self-insured plans because it is inextricably linked to the

issue of preemption as to insured plans. In both contexts, the impact of the 13% surcharge on a plan's choice of insurers must be evaluated. The preemption issue as to self-insured plans raises two additional, but related, considerations: imposition of the surcharge directly upon an ERISA plan and its effect on a plan's choice of a basic structure, *i.e.*, insurance versus self-insurance. Moreover, the Court should decide the question of preemption of the 13% surcharge as it applies to self-insured plans because that question was the very issue creating the conflict petitioners cited in seeking *certiorari*.

II. The 13% surcharge as applied to self-insured ERISA plans "relates to" them for purposes of ERISA's preemption provision because (a) self-insured plans themselves pay the surcharge to the hospitals—there is no intervening insurance company that pays the hospital and passes the surcharge through to the plans in the form of higher premiums—and (b) the surcharge applies to self-insured plans solely by virtue of the central function that makes them ERISA-covered plans—the payment of health care benefits. This particular characteristic of the surcharge distinguishes it from state laws imposing directly upon self-insured plans requirements affecting the plans by reason of their property ownership, utility use, hiring of employees and other similar activities.

In addition, the surcharge "relates to" the self-insured plans because it is designed to induce them to alter drastically their basic structure and administration by changing from self-insurance administered on a national or multistate regional basis by entities of their choice to insurance with the Blues in New York. Such a change would create severe administrative burdens for such plans and subject them to New York insurance laws and regulations from which Congress, in the "deemer" clause of ERISA's preemption provision, expressly protected them. Furthermore, becoming insured with the Blues in New York would interfere with the uniform plan structure and

administration throughout the country or multistate region that is the hallmark of interstate plan operations, especially those of national plans that are collectively bargained, as are the Railroad Plans.

The insurance "saving" clause of ERISA's preemption provision does not preserve the 13% surcharge from preemption. The surcharge is a law regulating hospital rates, not insurance. Furthermore, the deemer clause of the preemption provision precludes application of the saving clause to any state law to the extent that it "relates to" self-insured plans. Thus, since the 13% surcharge "relates to" self-insured plans, the saving clause does not insulate the surcharge from preemption as it applies to them.

ARGUMENT

New York's effort to improve the competitive position of the Blues by imposing a 13% surcharge on other payors of inpatient hospital bills penalizes both commercially insured and self-insured plans. In the case of insured ERISA plans, the impact of the surcharge comes by way of premium increases by the insurers. In the case of self-insured ERISA plans, the impact is direct and immediate. The surcharge is paid to the hospitals by the plans themselves. Though the aim of the statute is the same in both situations—to induce plans to switch to the Blues "by giving the Blues a competitive advantage over commercially insured, self-insured funds" and others (Pet. App. at 27, 56)[1]—and while in our view a statute so designed runs afoul of ERISA's preemption provision whether applied to commercial insurers or to self-insured plans, the situations are not identical. As the United States acknowledges: "Application of the 13% surcharge

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[1] We adopt "Pet. App." to refer to the Petitioners' Appendix to their petition for *certiorari* in Docket No. 93-1414 and "JA" to refer to the Joint Appendix filed by Petitioners with their briefs on the writ.

to 'self-insured funds' may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves." Brief for the United States as *Amicus Curiae* Supporting Petitioners at 12 n.3 (hereinafter "Gov't Br."); Brief for the United States as *Amicus Curiae* on Petitions for a Writ of *Certiorari* to the United States Court of Appeals for the Second Circuit at 14 n.5 (hereinafter "Gov't Br. on Pet.").

The United States thus appears to appreciate that the argument that the 13% surcharge "relates to" ERISA plans is stronger where the surcharge is levied upon the plan itself than where the surcharge impacts the plan through the intermediary of an insurer. Moreover, in the case of self-insured plans, there is an additional distinguishing factor relating to the plan's basic structure and administration. Not only does the statute designedly color the plan's choice of insurance carrier, but it also affects the choice of insurance as against self-insurance.

In view of the interrelationship of the issues respecting insured and self-insured ERISA plans—both their similarities and dissimilarities—it would on the face of it seem desirable for the Court to examine them together. Nevertheless, petitioners do not discuss the discrete problems raised by application of the surcharge to self-insured plans, and the Government expressly declines to brief the question, resting on its suggestion that the Court remand that issue to the lower courts if it reverses the court of appeals respecting exaction of the surcharge from commercially insured ERISA plans. Gov't Br. at 12 n.3, 28 n.20.

In this brief, we show, first, that the Government's recommendation is grounded in a demonstrably mistaken understanding of the proceedings below and, to the extent it speaks to the Court's discretion, is unwise. We then show that application of the surcharge to self-insured ERISA plans is barred by ERISA's preemption provision.

I. THE QUESTION OF WHETHER OR NOT ERISA PREEMPTS APPLICATION OF NEW YORK'S 13% SURCHARGE TO SELF-INSURED ERISA PLANS IS PROPERLY BEFORE THE COURT AND SHOULD BE DECIDED.

Notwithstanding the Solicitor General's expressed doubts, the issue of preemption of the surcharge as applied to self-insured ERISA plans was unquestionably raised, argued, and decided both in the district court and the court of appeals and was one of the issues as to which this Court granted *certiorari.* Because of the importance of this question and the irreconcilability between our view of the lower court proceedings and the Solicitor General's, we include in the Appendix ("App.") detailed citations to the record in the lower courts. In summary, that record shows the following:

The issue of preemption respecting self-insured plans was raised in the district court by the plaintiffs as fiduciaries for such plans. While the Government, in its Brief as *Amicus Curiae* in support of the petition for *certiorari,* maintained the contrary (Gov't Br. on Pet. at 14 n.5), it now acknowledges, though rather elliptically, its error.[2] Gov't Br. at 11-12 n.3. As to the proceedings before the district court, the affidavits from the plaintiffs in support of their motions for summary judgment were replete with references to self-insured plans, App. at 2a, and the district court granted those motions in all respects pertaining to the 13% surcharge. Pet. App. at 89-90. Moreover, the court in its opinion made quite clear that

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[2] It now says, "In fact, the complaints filed in this case may be read to allege that one or more of the plaintiffs is a self-insured plan, see J.A. 93, at ¶ 18, and the complaints allege that several of the insured-[sic] plaintiffs in this case are fiduciaries for self-insured funds that are ERISA plans, see J.A. 69, 91-93." Gov't Br. at 12 n.3. To say that parties alleged standing to raise an issue is not quite the same thing as to concede that they did in fact raise the issue. But since in fact they did, this seems close enough to be taken as a concession.

its judgment applied to self-insured plans. Thus, the court specifically held, citing *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), that the insurance saving clause of ERISA § 514(b)(2)(A) cannot save the surcharge *as applied to self-insured plans* because "self-insured plans do not engage in the 'business of insurance' as a matter of law." Pet. App. at 79.

The Solicitor General believes it is "not clear" that the district court's injunction—which was directed " 'against any commercial insurers or HMOs in connection with their coverage of any ERISA plans' "—extended to insurers in their capacity as administrators of self-insured plans. Gov't Br. at 12 n.3 (citation omitted). But it is the court's judgment that is controlling, and that judgment plainly extended to self-insured plans. In any event, the Solicitor General's doubt is unfounded. He evidently believes that the term "coverage" in the injunction might refer only to insured coverage. But the court held that HMOs are not engaged in the business of insurance (Pet. App. at 79 & n.14), and, accordingly, the court's use of the term "coverage" respecting both HMOs and commercial insurers must be taken to include coverage under self-insured plans that they administer.

Moreover, the court removed any possible question by squarely ruling, in a post-judgment order of which the Solicitor General may be unaware, that the court's judgment encompassed self-insured plans. After the court had stayed that judgment as to the 13% surcharge pending appeal, a dispute arose as to whether a plaintiff, Travelers, in its capacity as fiduciary for two self-insured ERISA plans that were not parties, the Railroad Plans, was obliged to pay the surcharge on their behalf. Noting that "two self-insured ERISA plans for which Travelers provides administrative services . . . had instructed Travelers not to pay the 13% differential," the court ordered Travelers to pay. App. at 4a-5a and Ex. 8 thereto.

As to the appeal, the Solicitor General says:

> "Since no cross-appeal was taken from the district court's order, the application of the 13% surcharge to 'self-insured fund[s]' was not raised by any party before the court of appeals. Nor did the court address it *sua sponte*." Gov't Br. at 12 n.3.

The Solicitor General is mistaken. (Not, to be sure, with respect to the absence of a cross-appeal regarding any surcharge. But this is a fact without any significance that we can discern, since the judgment on the surcharges was wholly in plaintiffs' favor.) The appeal carried to the court of appeals that judgment, which covered the 13% surcharge as applied to self-insured funds. The appellants' statements of questions presented embraced that issue. And it was briefed by the parties. (See App. at 5a-6a, especially the citations to passages in the appellants' briefs.) Of particular significance is the opposition of appellant—here petitioner—Hospital Association of New York State ("HANYS") to this *amicus*' motion, subsequently granted, for leave to file a brief with the court of appeals:

> "First, the Court already has been favored with briefs from five sets of parties and from four amicus curiae, covering all of the issues. *In particular, the interests of all self-insured plans, and the Railroad Plans specifically, are alrready represented.* Plaintiff the Travelers Insurance Company ('Travelers') acts as fiduciary or otherwise provides administrative services to self-insured plans, including the Railroad Plans. Travelers has specifically lodged its complaint in such capacity. (Citation omitted.) The additional brief which the Railroad Plans seek to submit is merely cumulative . . . ." (Emphasis added.) App. at 7a and Ex. 9 thereto.

Thus the issue as to self-insured plans was clearly in play in the court of appeals; and while the court did not in its opinion distinguish between self-insured plans and insured plans, there was no reason for it to do so. App.

at 8a. The court simply referred to the 13% surcharge in general terms without distinction as to payor—whether commercial insurer or self-insured plan—and if its rationale be thought to be framed primarily with reference to insured plans, that rationale surely applied *a fortiori* to self-insured plans. If anything can be said to be missing, it is simply the equivalent of an addendum stating that "the same is true of self-insured plans".[3]

In this Court, the petitioners sought review of the judgment below insofar as it struck down the 13% surcharge and did not, naturally, excise from their request that element of the judgment applying to self-insured plans. To the contrary, the first issue identified in the petition filed by HANYS expressly raised the question of preemption of New York's different "set of [hospital] rates for patients covered by[, among others,] self-insured plans," and the Court granted that petition as to that issue. Brief for Petitioner HANYS on Writ of *Certiorari* to the United States Court of Appeals for the Second Circuit at (i); *HANYS* v. *Travelers Ins. Co.*, Dkt. No. 93-1415, 63 U.S.L.W. 3282, 3291 (U.S. Oct. 7, 1994). Moreover, the principal reason advanced by all petitioners for review was the asserted conflict between the decision below and that of the Third Circuit Court of Appeals in *United Wire, Metal and Machine Health and Welfare Fund* v. *Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir. 1993)—a case where *only self-insured plans and their participants* challenged various New Jersey hospital rate laws as preempted by ERISA.

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[3] If a full expression of the court of appeals' views respecting preemption as it applies to self-insured plans be thought helpful, the court supplied it in its subsequent opinion in *NYSA-ILA Medical and Clinical Services Fund* v. *Axelrod*, 27 F.3d 823 (2d Cir.), *petition for cert. filed sub nom. Chassin* v. *NYSA-ILA Medical and Clinical Services Fund*, 63 U.S.L.W. 3429 (U.S. Oct. 21, 1994) (No. 94-745).

In these circumstances, the Solicitor General's suggestion that the Court not decide the preemption issue as it relates to self-insured plans is without procedural warrant. It is also without merit as a matter of judicial policy. That issue is inextricably linked to the issue of preemption respecting insured plans. A central element of the preemption analysis respecting the surcharge's application to ERISA plans generally is the New York statute's purpose of influencing the plans' choice of insurers. That element must be evaluated as it relates to insured plans. It is even more pertinent in the context of self-insured plans, because that context includes two additional, but related, factors—the effect on the choice of a plan's basic structure, *i.e.*, self-insurance versus insurance, and the direct imposition of the surcharge on the plans. There is no sound reason for excluding self-insured plans from this assessment and leaving undecided the very question answered in *United Wire* that petitioners asserted created the conflict requiring resolution by this Court. This is especially so because, as we have noted *supra* at 11 n.3, that question was ruled upon by the Court of Appeals for the Second Circuit in a decision subsequent to the one here under review, a decision as to which a petition for *certiorari* is currently pending.

We add that it might be useful to the Court to be advised of the position of the United States respecting self-insured plans. In the court below, as the Solicitor General notes, the Secretary of Labor, appearing as *amicus curiae*, took the position "that the impact on choices made by plans provides a sufficient connection to trigger preemption" of the surcharges on the ground that they "relate to" ERISA plans, "but that—except for self-insured ERISA plans, which are protected by the 'deemer' clause—they are saved from preemption by the insurance savings clause." Gov't Br. at 14 n.4. The Secretary has now joined in the contrary position expressed in the brief for the United States with respect to insured plans, *id.* at 14 & n.4; but there is no indication that the United States

would extend that reversal of position to self-insured plans, which, the Solicitor General acknowledges, "may raise some distinct issues." *Id.* at 12 n.3.

II. SECTION 514(a) OF ERISA PREEMPTS APPLICATION OF NEW YORK'S 13% SURCHARGE TO SELF-INSURED ERISA PLANS.

New York's 13% surcharge as applied to self-insured ERISA plans "relates to" those plans for purposes of § 514(a) of ERISA, 29 U.S.C. § 1144(a), and, as applied to those plans, is not a law "which regulates insurance" under the saving clause of § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

A. The "Relates to" Clause.

The 13% surcharge imposed upon self-insured ERISA plans "relates to" them for purposes of § 514(a) because the surcharge is a *direct* levy upon such plans and attaches to the very activity that makes them ERISA-covered plans, the provision of health care benefits to plan participants. The plans pay the surcharge to the billing hospital; there is no intervening insurance company that pays the hospital and passes the surcharge on to the plans in the form of higher premiums.[4] And the provision of hospital care benefits to participants, the activity upon which the surcharge is fixed, is the very function that brings the plans, pursuant to § 3(1) of ERISA, 29 U.S.C. § 1002(1), under its coverage.

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[4] The distinction is not merely formal. When paid by ERISA plans in response to the hospital's bill, the amount is fixed by law. When passed through by a commercial insurer, the amount is determined by the realities of the competitive marketplace. Insurers must cover their costs or go out of business. Accordingly, substantial cost increases suffered by the insurer are almost certain to increase the costs of the insured plan. Still, the difference between a cost increase that the law requires a self-insured plan to pay and a cost increase that an insured plan is asked by its insurer to agree to pay is a real difference.

We submit that these facts, viewed against this Court's rulings that ERISA's preemption clause is to be accorded " 'its broad common-sense meaning,' " *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 47 (1987) (citations omitted), so as to give "effect to the 'deliberately expansive' language chosen by Congress," *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992) (citation omitted), make inescapable the conclusion that New York's 13% surcharge "relates to" self-insured ERISA plans. As in *Mackey* v. *Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the result is driven by the statutory language. To borrow and adapt the words of *amicus curiae* quoted by this Court in *Mackey* in applying the "relates to" phrase, " 'there is simply no logical way to construe the English language' " so as to conclude that a law imposing a 13% levy on bills paid by self-insured ERISA plans for inpatient hospital care of plan participants does not "relate to" such plans. *Mackey*, 486 U.S. at 836.

This is not to say that *any* tax or other requirement directly imposed upon an ERISA plan "relates to" that plan for purposes of § 514(a). Congress did not intend to wipe out a state's entire body of laws insofar as they apply to ERISA plans. As the Court observed in considering state judicial remedies in *Mackey*, no one would contend that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are preempted. *Id.* at 833. But here, the 13% surcharge is not only imposed directly upon self-insured plans, *it is imposed solely by virtue of the core plan function that causes the plan to fall within ERISA's ambit, the provision of health care benefits to plan participants.*

On this analysis, the term "relates to" would retain the exceedingly broad meaning that Congress intended and that this Court has articulated. It would not be artificially constricted so as to avoid unreasonable results. Such results would be avoided, instead, through interpretation

of the phrase "any employee benefit plan"—to which the challenged state law must "relate"—so that that phrase does not simply describe one type of enterprise among others, but defines an entity that is affected by the state law *because it is a benefit plan* rather than something else. Laws that apply to ERISA plans, then, solely because they own property, or use utilities, or hire employees, or engage in other activities just as do myriad other enterprises, would not "relate to" those plans even though the laws impose requirements directly upon the plans.

In short, because it is imposed directly on self-insured ERISA plans and targets their provision of health care benefits, the 13% surcharge for those reasons alone "relates to" those plans for purposes of § 514(a).[5] This, we submit, is the teaching of the two decisions of this Court holding state laws preempted as applied directly to self-insured ERISA plans by virtue of their performance of their core functions. In *Shaw* v. *Delta Air Lines, Inc.*, 463 US. 85 (1983), The Court ruled preempted a state statute prohibiting discrimination in employee benefit plans on the basis of pregnancy.[6] While the law did not apply only to ERISA plans, the Court had "no difficulty in concluding" that it "relate[d] to" such plans because it "pro-

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[5] Accordingly, the surcharge cannot be listed as among those laws of "general applicability" that this Court has noted may be more likely than other laws to have a "tenuous, remote or peripheral" effect on ERISA plans. *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 n.1 (1992). Rather, the surcharge is primarily addressed to and primarily affects ERISA plans. It is assessed upon a limited category of payors of hospital bills, and there can be little doubt that the vast majority of payments to hospitals by entities in this category are made either by insured or self-insured plans subject to ERISA. Hence, the 13% surcharge is hardly "generally applicable" even to all payors for hospital services, no less the population at large.

[6] For an explication of the Court's ruling as to a second statute involved in *Shaw*, see *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 585 (1992).

hibit[ed] employers from structuring their employee benefit plans" in a certain manner. Id. at 96-97. And in *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), the Court ruled that § 514(a) applied to a state law barring both ERISA and non-ERISA plans from asserting subrogation with respect to a beneficiary's tort recovery.[7] Any number of decisions in the courts of appeals are of similar import. See, *e.g.*, *Travitz* v. *Northeast Dep't ILGWU Health and Welfare Fund*, 13 F.3d 704, 709-10 (3d Cir. 1994) (state bar against recovery from tortfeasor of amounts otherwise payable by self-insured plan "relates to" that plan); *Auto Club Ins. Ass'n* v. *Health and Welfare Plans, Inc.*, 961 F.2d 588, 592-93 (6th Cir. 1992) (state coordination of benefits rule, as applied to self insured plans, "relates to" them); *Mullenix* v. *Aetna Life and Casualty Ins. Co.*, 912 F.2d 1406, 1408-09 (11th Cir. 1990) (application to self-insured plans of state mandate that chiropractic services be covered "relates to" such plans); *Brown* v. *Granatelli*, 897 F.2d 1351, 1353-55 (5th Cir. 1990) (application to self-insured plans of state requirement that health insurance policies cover newborns with congenital defects "relates to"

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[7] Other § 514(a) decisions by the Court accord with this analysis. In three cases, the challenged state laws did not apply directly to ERISA plans, but the Court held them preempted nonetheless because there was a substantial indirect impact that bore specifically on the plans' activities in providing benefits. *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133 (1990); and *Greater Washington Board of Trade*, 113 S. Ct. 580 (1992). In a fourth case, on the other hand, the Court upheld state laws that impacted ERISA plans only indirectly and that did not impinge upon interests, such as uniformity, that ERISA was designed to secure. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1 (1987). Finally, in *Mackey*, 486 U.S. 825 (1988), while the state law—a general garnishment statute—did apply directly to ERISA plans, it was not aimed specifically at the activities they conducted because they were benefit plans. In any event, the Court viewed other ERISA provisions as evidencing a legislative intent under which such statutes were permissible. For a similar ruling, see *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

such plans even if they have purchased stop-loss insurance); *PPG Indus. Pension Plan A (CIO)* v. *Crews*, 902 F.2d 1148, 1150-51 (4th Cir. 1990) (state law prohibiting particular method of integrating pension and workers' compensation benefits as applied to self-insured plans "relates to" such plans); *Baxter* v. *Lynn*, 886 F.2d 182, 185 (8th Cir. 1989) (state law that "prohibit[s] employers from structuring their [self-insured plans] in a manner that requires reimbursement" by plan participant who recovers from third-party "relates to" such plans).[8]

There is in addition a further reason why New York's 13% surcharge "relates to" self-insured plans: It is designed to induce them, although they may be nationwide and collectively bargained, as are the Railroad Plans, to change their basic structure and administration—from self-insurance administered on a national or multistate regional basis by the entity of their choice to insurance with the Blues in New York.

A primary goal of the 13% surcharge when enacted was to encourage providers of health care benefits, be they commercial insurers or self-insured plans, to insure those benefits with the Blues. The court of appeals found that the surcharge "was meant to ' "level [the] playing field" ' for the Blues . . . (citations omitted). The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues." JA 37. See also Gov't Br. at 9 (the surcharges "are *designed* to give the Blues a rate advantage in the marketplace, thereby encouraging more customers to purchase coverage from the

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[8] The decision of the Third Circuit Court of Appeals in *United Wire*, 995 F.2d 1179 (3d Cir. 1993), appears to depart from this approach. We think it incorrect, but in any event, as we hereafter note in the text, the 13% surcharge is materially different from, and more pernicious than, the laws involved in *United Wire* in that New York's surcharge designedly interferes with a plan's determination of what its basic structure and administration should be.

Blues and helping maintain the solvency of the Blues." (Emphasis added.)).

By penalizing self-insured plans that choose not to switch to insurance with the Blues in New York, New York seeks to compel those plans to reverse their decisions to be self-insured. Those decisions are made by large and mature plans, like the Railroad Plans, for very good reasons. Such plans can predict with substantial accuracy what their benefits and related expenses will be in any given year, thus minimizing the need to insure against the risk that benefits and expenses will exceed available funds. On the other hand, becoming insured triggers the application to the plans of a long list of burdensome and costly state insurance laws and regulations, such as mandated benefit laws, mandated provider laws and premium taxes, from which Congress plainly intended, through the deemer clause in § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B), to protect self-insured plans.[9]

In *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724 (1985), this Court recognized, and gave effect to, this legislative intent in a fashion directly relevant here. The Court held that a state law requiring that certain minimum mental health-care benefits be provided in insurance policies "relate[d] to" insured ERISA plans under § 514(a) but was "saved" under the insurance saving clause. The Court ruled, however, that the law could not be "saved" as to self-insured plans because of the deemer clause. In language closely in point here, the Court took note of Congress' intent to afford a special measure of protection to self-insured plans, an intent confirmed by post-ERISA legislative consideration:

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[9] The deemer clause provides, in effect, that state laws that "relate to" self-insured plans under § 514(a) of ERISA cannot be applied to those plans even if the laws are not preempted, as applied to insured plans, because they are laws "which regulate insurance" for purposes of the saving clause. § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B).

"We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter.[25]

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[25] A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and non-insured plans: 'To the extent that [certain programs selling insurance policies] fail to meet the definition of an "employee benefit plan" [subject to the deemer clause], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these "products".' H.R. Rep. No. 94-1785, p. 48. A bill to amend the saving clause to specify that mandated-benefit laws are preempted by ERISA was reported to the Senate in 1981 but was not acted upon." (Citation omitted.) *Id.* at 747 & n.25.

Congress' differentiation in ERISA between insured and self-insured plans and its determination to afford self-insured plans greater insulation from state regulation, all as recognized by this Court in *Metropolitan Life*, strongly support the view that the 13% surcharge as applied to self-insured plans "relates to" them for purposes of § 514(a) even if a contrary conclusion were reached regarding application of the surcharge to insured plans.

We should note here, as we did in the court of appeals without contradiction by petitioners, that, under New York law, self-insured plans apparently cannot avoid the 13% surcharge by hiring the Blues to administer their self-insured programs. The surcharge is imposed on all payments for services provided to patients "enrolled in a self-insured fund which provides for reimbursement directly to general hospitals." N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney Supp. 1993). The exclusion from the surcharge that favors the Blues is for payments for services "provided in accordance with *policies writ-*

ten" by the Blues. *Id.* at § 2807-c(1)(a) (emphasis added). Self-insured plans do not buy "policies written" by the Blues, or by any other insurer, and so make no payments to hospitals in accordance with any such "policy." Thus, even if administered by the Blues, self-insured plans are apparently required to pay the surcharge. They must become insured by the Blues to avoid it.

Even if the surcharge were not applicable to self-insured plans administered by the Blues, its impact upon national, collectively bargained, self-insured plans—like the Railroad Plans—would still be intolerable. To be sure, the plans would not have to buy insurance from the Blues to avoid the penalty, but their choice would remain unacceptable: pay the surcharge or appoint a different administrator in New York than elsewhere, even though uniform administration on a nationwide or multistate regional basis has long been a hallmark of interstate plan operations, as is the case with the Railroad Plans, and a practice collectively bargained, as is also the case with the Railroad Plans. Indeed, such uniform administration is likely to be the *modus operandi* for most nationwide health care benefit plans collectively bargained by management and labor, since it diminishes disparate treatment of plan participants and beneficiaries depending upon where they happen to live.

A plan with otherwise uniform administration that is forced upon pain of the surcharge to use a separate administrator—the Blues—in New York will be saddled with administrative burdens and inefficiencies that it does not now have. Among other things, such a plan would need to negotiate separate administrative service contracts, meld claims and other reports of separate administrators with separate information systems into a unified format, and make sure that the administrators interpret plan provisions—such as what services are medically necessary and what charges are reasonable and customary—in the same fashion.

And what if other states, following New York's lead, elected to penalize self-insured, collectively bargained, nationwide, ERISA-covered plans for failure to become insured with companies or to appoint administrators that for policy reasons these other states favored, companies and administrators that would not be the New York Blues and in all probability would be different from state to state? Surely, ERISA does not contemplate that a plan be faced with appreciable penalties in any number of states if it refuses to balkanize its structure and administration, since such a choice would threaten the uniformity that Congress in ERISA sought to promote. See 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams). The preemption clause was expressly designed to protect ERISA plans from efforts by states to require "the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990). See also *Shaw*, 463 U.S. at 105 ("By establishing benefit plan regulation 'as exclusively a federal concern,' (citation omitted), Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees.").

That plans like the Railroad Plans are the product of nationwide collective bargaining adds special force to their concern over the threat posed by the 13% surcharge to a comprehensive, uniform scheme of benefit administration. This Court has recognized that where ERISA-covered plans "emerge from collective bargaining, the additional federal interest in precluding state interference with labor-management negotiations calls for preemption of state efforts to regulate" their terms. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). See also *PPG Indus. Pension Plan A (CIO)* v. *Crews*, 902 F.2d 1148, 1151 (4th Cir. 1990) (same). "As a subject of collective bargaining, [plan] terms themselves become expressions of federal law, requiring preemption of intru-

sive state law." *Alessi*, 451 U.S. at 526. The New York surcharge attaches to self-insured, collectively bargained, ERISA-covered plans because the collective bargainers chose not to negotiate the kind of arrangement that New York favors, *i.e.*, insurance with the Blues. Such a law certainly interferes with and intrudes upon the federally protected bargaining process.

Respondents have cited a number of decisions holding preempted state laws affecting ERISA plans in ways analogous to the impact of the 13% surcharge. We draw the Court's attention in particular to *National Elevator Industry, Inc.* v. *Calhoon*, 957 F.2d 1555 (10th Cir.), *cert. denied*, 113 S. Ct. 406 (1992), a case remarkably similar to the one at bar insofar as the applicability of ERISA's "relates to" clause is concerned. There, an industry association claimed that ERISA preempted a ruling by the Oklahoma Commissioner of Labor requiring employers to pay helpers on state projects at the higher wage level applicable to mechanics, unless the helpers had enrolled in a training program approved by the federal Bureau of Apprenticeship Training ("BAT"). The employers, however, funded an ERISA-covered, national, helpers training plan that had apparently not been approved by BAT. In a conclusion equally applicable in this case—one need only substitute "hospital rates" for "wages"—the court wrote:

> "We accept, as a general proposition, the state's right to regulate wages. But a wage law that provides an option favoring certain ERISA plans and benefits (BAT approved plans) over other ERISA plans and benefits [the employers' plan] is not a law of 'general application' and may be used to effect change in the administration, structure and benefits of an ERISA plan. If a state is permitted to use a prevailing wage scheme to single out and favor certain ERISA plans over other ERISA plans, the potential for abuse is great—a state could avoid ERISA's preemption provision and covertly disturb

> or alter ERISA plans. We believe that [the Commissioner's] ruling would discourage non-BAT approved ERISA training programs and encourage changes to [the employers' plan], a national employee benefit program. We hold that [the Commissioner's] ruling applying the state's prevailing wage law does 'relate to' an employee benefit plan because the ruling's effects on [the employers' plan] are not 'tenuous, remote or peripheral.'" 957 F.2d at 1561.[10]

B. The "Saving" and "Deemer" Clauses.

A state law "which regulates insurance" is saved from preemption by § 514(b)(2)(A) of ERISA. This insurance "saving" clause is limited, however, by the so-called "deemer" clause § 514(b)(2)(B). The deemer clause forbids states from deeming an employee benefit plan "to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ."

We agree with respondents, who have fully briefed the question of the applicability of the saving clause to the 13% surcharge as applied to insured plans, that under any "common sense" reading of the surcharge provision, see *Metropolitan Life*, *supra*, the saving clause does not come into play. The surcharge regulates hospital rates, not insurance.

That the saving clause does not save the surcharge from preemption as applied to self-insured plans is even clearer. The deemer clause is the beginning and end of the inquiry. It precludes application of the saving clause to a law

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[10] The court also noted that the Commissioner's ruling "has the effect, and possibly the aim, of encouraging participation in a specific type of ERISA plan (BAT approved apprentice plans) while discouraging participation in a different type of ERISA plan," *i.e.*, the employers' plan. 957 F.2d at 1559.

preempted by § 514(a) because it "relates to" a self-insured ERISA plan.

In *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), this Court concisely and clearly stated the governing principles in terms that control in this case:

> "[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation *'relate[s] to'* the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." 498 U.S. at 61 (emphasis added).

Courts of appeal have applied these principles consistently to preempt, as applied to self-insured plans, any state laws that otherwise regulate insurance. *E.g.*, *Tri-State Machine, Inc.* v. *Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994); *Electro-Mechanical Corp.* v. *Ogan*, 9 F.3d 445, 450 (6th Cir. 1993); *Travitz* v. *Northeast Dep't ILGWU Health and Welfare Fund*, 13 F.3d 704, 710 (3d Cir. 1994); *Hampton Indus., Inc.* v. *Sparrow*, 981 F.2d 726, 729-30 (4th Cir. 1992). The result should be no different here.[11]

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[11] This Court observed in *Metropolitan Life* that Massachusetts had "never tried to enforce" in connection with self-insured ERISA plans a state law that otherwise regulated insurance, thus "effectively conceding" that ERISA would preempt such application. 471 U.S. at 735 n.14. Moreover, as we noted earlier, *supra* at 12-13, in the court of appeals the Secretary of Labor expressly acknowledged that the deemer clause protected self-insured plans from application of the insurance saving clause in this case.

CONCLUSION

In closing, we briefly take note of the efforts of petitioners to depict the court of appeals' decision as inimical to sound public policy. They contend that its decision would radically undermine the authority of the states to determine how best to distribute the costs of health care. But certainly preemption affecting only state laws, like New York's 13% surcharge, that are imposed directly on self-insured plans by virtue of their core function—the provision of health care benefits—would have no such effect. Nor would the further extension of preemption to laws designed to force insured ERISA plans to turn to state-favored insurance carriers. Moreover, the wisdom of requiring those who need and can afford health care to bear a large share of those costs, as does New York, rather than subsidizing hospitals with funds from taxes that are not levied on health care general revenues, is at least questionable. In any case, this general subject has been at the heart of Congressional debate over the last year, a debate that most expect will soon be renewed. Congress, in the preemption provision of ERISA, has marked that debate as the appropriate forum for petitioners to make their case.

The judgment of the Second Circuit should be affirmed.

Respectfully submitted,

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APPENDIX

APPENDIX

CITATIONS TO THE RECORD IN THE LOWER COURTS

A. District Court Proceedings.

1. *The complaints.* In separate complaints subsequently consolidated, Travelers Insurance Company ("Travelers") and the Health Insurance Association of America and other trade associations and insurance companies (collectively the "HIAA Plaintiffs") brought suit both as sellers (or associations of sellers) of commercial insurance to ERISA plans and as claims fiduciaries (or associations of claims fiduciaries) of self-insured ERISA plans. Travelers' Complaint ¶¶ 8, 10-13, 21 at JA 68 through JA 86; HIAA Plaintiffs' Amended Complaint ¶¶ 11, 13-17, 19 at JA 87 through JA 104. The HIAA Plaintiffs' complaint alleged that the "vast majority of persons covered by commercial health insurance and self-insured plans, . . . receive that coverage pursuant to employee benefit plans subject to ERISA," HIAA Plaintiffs' Complaint ¶¶ 5, 33 at JA 88-89, JA 97, and that the 13% surcharge would have the effect of forcing both insured and self-insured plans to increase the cost of their benefit plans, to reduce the scope of the benefits provided under their plans, or "to choose other means for [plan] funding," *id.* ¶¶ 5, 6 at JA 88-89; ¶¶ 33-37 (insured plans); 38-41 at JA 97-99 (self-insured plans). See also Travelers' Complaint ¶¶ 58-60 at JA 81-82. Both complaints prayed for a declaration that ERISA preempts the 13% surcharge as applied to self-insured and insured plans and an injunction barring defendants from enforcing that surcharge to self-insured and insured plans. Travelers' Complaint ¶¶ 62-63 at JA 82 & Prayer ¶ (c) at JA 85; HIAA Plaintiffs' Amended Complaint ¶ 53 at JA 101 & Prayer ¶¶ (ii), (iv) at JA 103-04.

2. *The summary judgment motions.* Both Travelers and the HIAA Plaintiffs moved for summary judgment on

various counts of their complaints, including in each case the count in which they claimed that ERISA preempts the 13% surcharge as applied to both insured and self-insured ERISA plans. Travelers' Notice of Motion for Summary Judgment at 2 (Ex. 1 hereto at 9a); Travelers' Complaint Count IV (13% surcharge) at JA 81-82; HIAA Plaintiffs' Notice of Motion at 2 (Ex. 2 hereto at 11a); HIAA Plaintiffs' Amended Complaint Count Two (13% surcharge) at JA 101. Moreover, in support of their motions, plaintiffs filed affidavits replete with statements of fact about self-insured plans, plaintiffs' involvement with them as claims fiduciaries, and the impact upon them of the 13% surcharge. Gutterman Affidavit ¶¶ 1-5, 7-9, 15-19, 25 at JA 115-118, JA 120-21, JA 122; Musco Affidavit ¶¶ 4, 6, 13-14 at JA 123-25; Donnelly Affidavit ¶¶ 4, 6 at JA 127-28; D'Amico Affidavit ¶ 4 at JA 130; Welch Affidavit ¶¶ 3-9, 11, 13 at JA 131-34; Shapland Affidavit ¶¶ 8, 9 at JA 140; Sujecki Affidavit ¶¶ 1,5, 6 at JA 298, JA 300.

That the summary judgment motions sought resolution of the issue of ERISA preemption of the 13% surcharge as applied to self-insured plans is also indicated in the affidavits submitted by defendants. Anderman Affidavit ¶¶ 28, 29 at JA 156-57; Klein Affidavit ¶ 43 at JA 189.

3. *The district court's decision.* The district court by order of February 4, 1993, granted plaintiffs' motions for summary judgment in all respects pertaining to the 13% surcharge. In addition, the court enjoined defendants from enforcing that surcharge (and the other surcharges that plaintiffs had challenged) "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." Pet. App. at 89-90.

In discussing the inapplicability of ERISA's insurance saving clause to self-insured plans, the district court held, citing *FMC Corporation* v. *Holliday*, 498 U.S. 52 (1990), that "those portions of the 13% Surcharge re-

ferring to self-insured plans could not possibly fall within the scope of the savings clause because . . . self-insured plans do not engage in the 'business of insurance' as a matter of law." Pet. App. at 79.[1] The court also ruled that, as a matter of law, HMOs are not engaged in the business of insurance. *Id.* at 79 & n.14.

In addition to granting summary judgment to plaintiffs with respect to the surcharges, the district court's order also enjoined enforcement of the surcharges against "any commercial insurers or HMOs in connection with their coverage of any ERISA plans." Pet. App. at 89-90.

4. *The district court's stay and related order.* Plaintiffs did not appeal the court's grant of summary judgment to them. Defendants, however, did appeal. They also moved to stay the district court's February 4, 1993, order pending appeal.

In opposition to defendants' stay motion—which the district court granted on February 9, 1993, but only with respect to the 13% surcharge, Pet. App. at 98—Travelers submitted the affidavit of Timothy F. Lyons. The Lyons Affidavit stated that the 13% surcharge applies to both insured and self-insured plans, Lyons Affidavit ¶ 8 at JA 324; that Travelers "is not even in a position to continue paying the surcharge with regard to its self-insured ERISA customers," id. ¶ 12 at JA 325; that because ERISA obli-

[1] To be sure, the court stated elsewhere in its opinion that the "Surcharges do not directly increase a plan's costs or effect the level of benefits to be offered. However, there can be little doubt that the Surcharges at issue will have a significant effect on the commercial insurers and HMOs which do or could provide coverage for ERISA plans and thus lead, at least indirectly, to an increase in plan costs" because plaintiffs will pass the surcharge on to their plan customers. Pet. App. at 71 (footnotes omitted). This analysis ignores self-insured plans since they themselves pay the surcharge. There is no passing through from insurer to plan in the form of higher premiums. Rather, the surcharge directly increases the plan's costs.

gates plan fiduciaries to use plan funds for the exclusive benefit of plan participants and beneficiaries, fiduciaries of self-insured plans could be expected to "refuse to continue to pay the 13% surcharge," *id.*; and that two non-party, self-insured plans for which Travelers provides administrative claims services had in late 1992 instructed Travelers "not to use any plan assets to pay the 13% surcharge" because the self-insured plans had concluded that ERISA preempted the 13% surcharge as applied to them, *id.* The self-insured plans to which the Lyons Affidavit referred were the Railroad Plans.

Shortly after the district court had stayed its order as to the 13% surcharge, Travelers advised the court by letter that the Railroad Plans had informed Travelers that the Plans' prior instruction not to pay the surcharge remained in effect. (Ex. 3 hereto at 14a.) The intervening defendants, in letters to the court, objected to nonpayment of the 13% surcharge by the Railroad Plans. (Exs. 4, 5 hereto at 17a, 20a.)[2] The NCCC also wrote to the district court explaining the NCCC's position as fiduciaries of the Railroad Plans. (Ex. 7 hereto at 25a.)

The district court resolved the dispute in an April 27, 1993, order that contained the following recitations:

> "WHEREAS . . . this Court held that federal law preempts certain provisions of the New York Public Health Law, including the 13% differential . . . ; and WHEREAS . . . this Court granted defendants' motion for a stay pending appeal of such . . . Order insofar as it concerns the 13% differential; and WHEREAS . . . two self-insured ERISA plans for which Travelers provides administrative services—[the Railroad Plans]—had instructed Travelers not to pay the 13% differential. . . ."

---

[2] Travelers responded in writing to intervening defendants' letters to the court. (Ex. 6 hereto at 23a.)

Furthermore, the order itself provided:

> "[T]he named parties to this action, including Travelers, in its capacity as claims fiduciary of the Railroad Plans, are directed to pay the 13% differential with respect to all hospital claims, where applicable [under New York's Public Health Law], whether incurred before or after the date hereof." (Ex. 8 hereto at 30a-31a.)

The court noted that its order applied to the trade association plaintiffs "only to the extent they serve directly as fiduciaries of ERISA plans" and that the order "does not impose on any person any obligation to pay the 13% differential except to the extent such obligation otherwise exists under the relevant contracts and/or New York law." *Id.*

B. Court of Appeals Proceedings.

1. *The briefs.* The briefs submitted on appeal by the appellants argued that ERISA did not preempt the 13% surcharge as applied to self-insured plans. The brief of intervenors-defendants-appellants The New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield (hereinafter "the Blues") stated: "[I]f New York is prohibited from charging commercial insurers and self-insured plans the DRG rate including the differentials, it is highly speculative what rate these payors will be required to pay." Brief at 21 (hereinafter "Blues App. Br."). In addition, the Blues acknowledged that the surcharges "discriminate against commercial insurers and self-funded plans by increasing their costs," *id.* at 29, and argued in response that "[c]ountless state laws will influence a plan's decision regarding whether to self-insure or purchase insurance from a commercial insuror or from a Blue Plan," *id.* at 30. See also *id.* ("[a]ny law or regulation which lowers the Plans' costs of doing business . . . would . . . impact commercially insured and self-insured ERISA

plans"); Blues App. Reply Br. at 1, 3, 5 n.6 (further attempts to refute discriminatory basis of 13% surcharge).[3]

The Blues responded directly to the contention in the *amicus* brief of the NCCC that the Railroad Plans would have to become insured through the Blues in New York to avoid payment of the 13% surcharge, Blues App. Reply Br. at 10 n.11, and that the surcharge hindered the uniform operation of self-insured plans nationwide, *id.* at 9-10. Finally, the Blues challenged the district court's ruling that the saving clause does not apply to self-insured plans and further argued that the deemer clause is similarly inapplicable. Blues App. Br. at 37-40.[4]

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[3] The briefs of the State of New York ("State") and the Hospital Association of New York State ("HANYS") generally treated all payors of the 13% surcharge collectively, and made few argumentative distinctions among them. Hence, most of their references to self-insured plans were merely descriptive of the statute. Brief for Defendants-Appellants State at 5, 7, 20, 28 n.32, 36 (hereinafter "State App. Br."); Brief on Appeal for Intervenor-Defendant-Appellant HANYS at 21, 25-26, 35 (hereinafter "HANYS App. Br."); HANYS App. Reply Br. at 2, 3, 9, 17. Additional references to self-insured plans were made in connection with appellants' contentions that the statute did not discriminate among payors based on their ERISA status; that uniform costs between the Blues and commercial insurers/self-insured plans could never be achieved; or that no evidence existed that the surcharge increased the cost of self-insured plans or otherwise provided an incentive for them to switch to the Blues. State App. Br. at 7, 20, 21; State App. Reply Br. at 5, 8-9, 8 n.11, 10 n.15; HANYS App. Reply Br. at 3, 5-6, 8-9, 15-16; Petition for Rehearing with Suggestion *En Banc* for Intervenor-Defendant-Appellant-Cross-Appellee HANYS at 2, 5, 8.

[4] Plaintiffs/appellees understood that appellants were challenging in the court of appeals the district court's ruling that the 13% surcharge was preempted by ERISA as applied to all applicable entities, including self-insured plans. App. Br. for the HIAA Plaintiffs-Appellees and Plaintiff-Appellee-Cross-Appellant Travelers at 2, 3, 7, 8, 11, 12, 13, 14, 18, 21, 22, 25, 29, 35, 36, 39, 45, 46, 47, 49-50, 62-65.

2. *The opposition to the filing of an amicus brief by the NCCC.* Counsel for intervenor-defendant-appellant HANYS submitted an affidavit (Ex. 9 hereto at 32a) opposing the NCCC's motion for leave to file an *amicus* brief with the court of appeals. Paragraphs 3 and 4 of the affidavit stated:

> "First, the Court already has been favored with briefs from five sets of parties and from four amicus curiae, covering all of the issues. In particular, the interests of all self-insured plans, and the Railroad Plans specifically, are already represented. Plaintiff The Travelers Insurance Company ("Travelers") acts as fiduciary or otherwise provides administrative services to self-insured plans, including the Railroad Plans. Travelers has specifically lodged its complaint in such capacity. *See* JA-57-63. The additional brief which the Railroad Plans seek to submit is merely cumulative and does not provide the Court with any new positions or perspectives necessary for a full presentation of the issues.
>
> More importantly, Intervenor-Appellant Hospital Association of New York State did not consent to the Railroad Plans filing an amicus brief because of the Plans' violation of the Stay Order of the District Court. A copy of our letter on behalf of the Hospital Association is annexed hereto. As the Railroad Plans' April 14, 1993 memorandum of law in support of their motion acknowledges (at p. 3), the Railroad Plans have chosen to defy New York law and have refused to continue paying the 13% differential on hospital charges which is at issue on this appeal. While the court below found that differential preempted by federal law, the court stayed the portion of its Order directed to such 13% differential, pending the outcome of this appeal. *See* JA-1863-69. Accordingly, the 13% differential remains in effect, and the Railroad Plans' refusal to pay it amounts to

willful defiance of the Stay Order and/or state law." Ex. 9 ¶¶ 3-4 at 33a-34a.

3. *The court's decision.* The court of appeals' opinion made few differentiations as to any one surcharge and almost none as to payor status. For example, the court stated that the "13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues . . . . Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage." JA 52. See also JA 53 ("The surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits." "[T]he surcharges here force ERISA plans to increase either plan costs or reduce plan benefits.").

The court of appeals also addressed in a general fashion the application of the saving clause to the surcharges, concluding that the 13% and 11% surcharges do not "regulate insurance." JA 56. Although "the surcharge laws provide for different payment rates based on whether a patient is uninsured, covered by an HMO, a commercial insurer or a self-insured health plan," the surcharge laws did not address matters typically within the purview of state insurance regulations. JA 57. Again, the court's analysis of the saving clause did not rely on differences in payor status.

EXHIBIT 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 3999 (LJF)
(CM 0773)

THE TRAVELERS INSURANCE COMPANY,

-against- *Plaintiff,*

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, and SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York,

Defendants,

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD and HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors.

NOTICE OF MOTION
FOR SUMMARY JUDGMENT

PLEASE TAKE NOTICE that upon the accompanying affidavit of Darrell M. Joseph, sworn to August 20, 1992, and the exhibit thereto, the accompanying affidavit of James M. Gutterman, sworn to August 17, 1992, and the exhibits thereto, the annexed Amended Statement pursuant to Rule 3(g) of the Civil Rules of this Court and the accompanying memorandum of law, plaintiff The Travelers Insurance Company, by its attorneys, Windels, Marx, Davies & Ives, will move this Court, before the Honorable Louis J. Freeh, United States District Judge,

in Courtroom 312, United States Courthouse, 40 Centre Street, Foley Square, New York, New York 10007, on the 21st day of August, 1992, at 9:00 o'clock in the forenoon of that day, or as soon thereafter as counsel may be heard, for an Order pursuant to Rule 56(c) of the Federal Rules of Civil Procedure granting summary judgment in its favor and against defendants on the ground that there exists no genuine issue as to any material fact with respect to Counts I, IV and VI of plaintiff's Complaint, and that plaintiff is entitled to judgment as a matter of law, and granting plaintiff such other and further relief as the Court may deem just and proper.

PLEASE TAKE FURTHER NOTICE that, pursuant to the schedule previously agreed to by the parties and approved by the Court, as reflected in the Court's endorsement of plaintiff's counsel's letter to the Court of August 11, 1992, filed on August 12, 1992, the parties shall adhere to the following briefing schedule: (1) defendants' (including intervenors') papers in opposition to plaintiff's motion and in support of any cross-motions for summary judgment are due to be served on or before October 2, 1992; (2) plaintiff's reply papers are due to be served on or before October 16, 1992; and (3) any additional papers from defendants (including intervenors) are due to be served on or before October 22, 1992.

Dated: New York, New York
August 21, 1992

WINDELS, MARX, DAVIES & IVES

By: /s/ Craig P. Murphy
CRAIG P. MURPHY (CM 0773)

Attorneys for Plaintiff
The Travelers Insurance Company
156 West 56th Street
New York, New York 10019
(212) 237-1000

EXHIBIT 2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

92 Civ. 5419 (LJF)

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, and PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs,

-against-

MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, MARY JO BANE, in her Official Capacity as Commissioner of Social Services of the State of New York, SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York, and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York,

Defendants.

NOTICE OF MOTION

PLEASE TAKE NOTICE that, upon the pleadings; the annexed statement pursuant to Rule 3(g) of the Civil Rules for the Southern District of New York; the accompanying Affidavits of Thomas D. Musco, and the annexed exhibit, executed on August 18, 1992, Vincent W. Donnelly, executed on August 18, 1992, Raymond A. D'Amico, executed on August 13, 1992, Mark R. Welch, executed on August 18, 1992, John P. Burke, executed

on August 19, 1992, Robert B. Shapland, executed on August 14, 1992, James R. Hibbitts, executed on August 13, 1992, Thomas L. Reddy, Sr., executed on August 17, 1992, and Angelo V. D'Ascoli, executed on August 19, 1992; the undersigned will move this Court, the Honorable Louis J. Freeh presiding, in Room 540, United States Courthouse, Foley Square, New York, New York, on October 26, 1992, at 9:00 a.m. or as soon thereafter as counsel may be heard, for an order:

(a) pursuant to Rule 56(a) of the Federal Rules of Civil Procedure, granting summary judgment in favor of all plaintiffs and against all defendants on counts one through three of the Amended Complaint and enjoining enforcement of, and declaring invalid, Section 2807-c(1)(b) of the New York Public Health Law and Sections 346 and 348 of the New York Omnibus Revenue Act of 1992, insofar as they impose Surcharges increasing hospital charges for patients covered by employee welfare plans subject to ERISA that use commercial insurance, self-insurance, or health maintenance organizations to provide benefits to participants or beneficiaries; and

(b) granting plaintiffs such other and further relief as the Court may deem just and proper.

Further grounds for this motion are set forth in the accompanying memorandum of law.

Dated: New York, New York
August 21, 1992

PAUL, WEISS, RIFKIND, WHARTON
& GARRISON

By: /s/ Sidney S. Rosdeitcher
SIDNEY S. ROSDEITCHER (SR-3127)
1285 Avenue of the Americas
New York, New York 10019-6064
(212) 373-3000

Attorneys for Plaintiffs The Health Insurance Association of America, The American Council of Life Insurance, The Life Insurance Council of New York, Inc., Mutual of Omaha Insurance Company, The Union Labor Life Insurance Company, and Professional Insurance Agents of New York, Inc. Trust

HOGAN & HARTSON

By: /s/ Clifford D. Stromberg
CLIFFORD D. STROMBERG
(CS-3510)
Columbia Square
555 13th Street, N.W.
Washington, D.C. 20004-1109
(202) 637-5600

Attorneys for Plaintiffs Aetna Life Insurance Company and Aetna Health Plans of New York, Inc.

EXHIBIT 3

WINDELS, MARX, DAVIES & IVES
156 West 56th Street
New York, NY 10019
(212) 237-1000

March 24, 1993

Craig P. Murphy
(212) 237-1234

BY HAND

Hon. Louis J. Freeh
United States District Judge
United States District Court
Southern District of New York
United States Courthouse
40 Centre Street, Room 540
New York, New York 10007-9998

Re: The Travelers Ins. Co. v. Cuomo, *et al.*,
No. 92 Civ. 3999 (LJF)

Dear Judge Freeh:

I represent plaintiff The Travelers Insurance Company in connection with the above matter. I am writing to inform the Court of a recent development concerning the partial stay pending appeal which this Court granted on February 9, 1993.

On February 3, 1993, this Court granted plaintiff's motion for summary judgment and enjoined defendants from enforcing the three hospital surcharges at issue in this litigation on the grounds that they are preempted by ERISA. On February 9, 1993, this Court stayed its February 3 order to the extent it enjoined enforcement

of the 13% surcharge, but denied a stay of the order regarding the 9% and 11% surcharges.

As Your Honor knows, The Travelers brought this suit in its capacity as fiduciary of two ERISA plans, the B.H. Aircraft Plan and the Sheridan Catheter Plan, under Section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). These plans are described, respectively, in paragraphs 18 and 21 of the complaint. The Travelers also provides commercial health insurance and/or administrative services in connection with other ERISA plans.

In the affidavit of Timothy F. Lyons, Esq., sworn to on February 8, 1993, which was submitted in opposition to the defendants' and certain intervenors' motions for a stay pending appeal, The Travelers explained that in late 1992, two non-party self-insured ERISA plans had instructed The Travelers to stop using plan assets to pay the 13% surcharge. The plans at issue are the Railroad Employees National Early Retirement Major Medical Benefit Plan and the Railroad Employees National Health and Welfare Plan (referred to collectively as "the Railroad Plans").

Following this Court's February 9, 1993 stay order, The Travelers again communicated with the Railroad Plans regarding the 13% surcharge. Within the last few days, the Committees charged with governance of the Plans have advised The Travelers that in light of the fact that the Railroad Plans are not parties to the case in which this Court's orders of February 3 and 9, 1993 were issued, and in consideration of the prohibition laid down by ERISA that plan assets not be disbursed to provide benefits for persons other than plan participants and beneficiaries, the Committees could not, consistently with their fiduciary duties under applicable law, reverse their earlier instructions to The Travelers and authorize the use of plan assets to pay the 13% surcharge.

Because the Railroad Plans are not parties to this litigation, it is our understanding that they are not subject

to this Court's February 9, 1993 stay order. Accordingly, The Travelers has concluded that it must follow the instructions of the Railroad Plans. However, because The Travelers, in its capacity as fiduciary of the B.H. Aircraft Plan and the Sheridan Catheter Plan, is a party to this litigation and subject to the stay order, I wanted to bring this matter to Your Honor's attention. I also wish to note that during the pendency of the appeal from Your Honor's February 3 order, The Travelers will continue paying the 13% surcharge on behalf of the Sheridan Catheter Plan, the B.H. Aircraft Plan and the other ERISA plans in connection with which The Travelers provides commercial health insurance. The Travelers has also recommended that all self-insured ERISA plans which receive administrative services from The Travelers continue paying the 13% surcharge.

Very truly yours,

/s/ Craig P. Murphy
CRAIG P. MURPHY

CPM:dr
cc: All Counsel in 92 Civ. 3999 (LJF), and 92 Civ. 5419 (LJF) (by facsimile)

bcc: Benjamin W. Boley, Esq. (by facsimile)
James M. Michener, Esq. (by facsimile)
Timothy F. Lyons, Esq. (by facsimile)
Darrell M. Joseph, Esq.

All HIAA Action Plaintiffs (by facsimile) (except the Aetna entities)

EXHIBIT 4

BREED, ABBOTT & MORGAN
Citicorp Center
153 East 53rd Street
New York, N.Y. 10022-4858

(212) 888-0800

March 29, 1993

BY HAND

Hon. Louis J. Freeh
United States District Judge
United States Courthouse
Foley Square
New York, New York 10007

Re: *Travelers v. Cuomo*, 92 Civ. 3999 (LJF)

Dear Judge Freeh:

In his March 24, 1993 letter, Travelers' attorney, Craig Murphy, Esq., informs the Court that two self-insured ERISA plans for which Travelers acts as fiduciary have instructed Travelers to refuse to pay the 13% hospital differential, and that Travelers has chosen to abide by such position. This letter responds on behalf of intervenors Empire Blue Cross and Blue Shield and The New York State Conference of Blue Cross and Blue Shield Plans and, in accord with Your Honor's pre-motion procedures, prays leave to move for an Order enforcing your February 9, 1993 Order (the "Stay Order") and for whatever other relief this Court may deem appropriate.

The basic premise of Mr. Murphy's letter is inconsistent with Travelers' position in this action and is incorrect as a matter of law and fact. As purported justification

for the failure of these plans to pay the 13% differential, Mr. Murphy asserts: "Because the Railroad Plans are not parties to this litigation, it is our understanding that they are not subject to this Court's February 9, 1993 stay order." Thus, Mr. Murphy presses for the bizarre result that as supposed non-parties, the Railroad Plans obtain rights pursuant to the Court's February 3, 1993 decision greater than the parties themselves.

The effect of the Stay Order is to leave the 13% differential in place and applicable to all entities subject to it. Under the stay, the 13% remains the law, and the Railroad Plans, like all other similarly situated persons, continue to be obligated to pay it. Indeed, Mr. Murphy appears not to dispute but rather to acknowledge that State law requires payment of the 13% differential, stating: "The Travelers has also recommended that all self-insured ERISA plans which receive administrative services from The Travelers continue paying the 13% surcharge."

The Stay Order applies to Travelers with respect to all of the ERISA plans, whether fully insured or self-funded, for which Travelers acts as a fiduciary. Indeed, in its complaint, Travelers appears to sue not only on its own behalf but also on behalf of those ERISA plans for which it acts as a fiduciary. In fact, in Travelers' capacity as fiduciary, Travelers advised this Court, through ¶¶ 12-13 of the Lyons Affidavit submitted in opposition to Defendants' motion for a stay, of the very same information set forth in Mr. Murphy's current letter, *i.e.*, that self-insured plans would refuse to pay the differential and would direct Travelers not to pay it. This Court ruled against Travelers on the motion, finding specifically that ". . . ERISA plans . . . will only suffer monetary damages if the court's Order is stayed during appeal." Stay Order at 5. Now, once again, Travelers attempts to be relieved of its responsibility as fiduciary to make the payments. This action cannot be countenanced by the Court.

In any event, these plans are bound by Your Honor's Orders and subject to "contempt" as persons with "actual

notice" of the decree[s] of February 3 and 9, 1993. *Vuitton v. Carousel Handbags*, 592 F.2d 126, 129-30 (2d Cir. 1979). Particularly so where, as here, both such plans are plainly acting in concert with the plaintiff in this litigation, Travelers. *See* Fed. R. Civ. P. 65(d).

By refusing to pay the 13% differential, Travelers, as the fiduciary for these two Railroad Plans, has violated the law and is subject to whatever penalties and remedies may be available to the State and any other relevant person. Moreover, by altering the status quo they would appear exposed to whatever sanctions or other corrective actions this Court may deem in order, regardless of what decision ultimately may emanate from the Court of Appeals. *Cf. United States v. United Mine Workers*, 330 U.S. 258 (1947).[1] Such relief appears called for because the sole grounds asserted for failure to comply is an obvious misreading, indeed flouting, of Your Honor's Stay Order. It is of this Court's Stay Order that we would seek enforcement.

Respectfully,

/s/ Robert A. Bicks
ROBERT A. BICKS
BARTLEY J. COSTELLO

cc: All counsel

---

[1] The law is clear that under Fed. R. Civ. P. 62(c), the district court has jurisdiction to issue injunctions or other orders which preserve the status quo pending appeal. *See International Ass'n v. Eastern Airlines, Inc.*, 847 F.2d 1014, 1018 (2d Cir. 1988) (noting that Fed. R. Civ. P. 62(c) permits the district court to issue orders which preserve the status quo pending appeal). Moreover, as a leading commentator has stated: "[I]t has been held that the district court, which has granted an injunction pending appeal, may consider whether defendant is in contempt for violation of that order, even while the appeal is still pending." C. Wright & A. Miller, *Federal Practice and Procedure*, § 2905 at 325.

EXHIBIT 5

SHERRIN & GLASEL
Attorneys & Counselors at Law
74 North Pearl Street
Albany, New York 12207

(518) 465-1275

March 30, 1993

Hon. Louis J. Freeh
United States District Court
United States Courthouse
Foley Square
40 Centre Street, Room 540
NY, NY 10007-9998

Original Via Overnight Mail
Copy Via Hand Delivery

Re: *Travelers, et al. v. Cuomo, et al.*, 92 Civ. 3999, (LJF)

Dear Judge Freeh:

We are writing on behalf of the Hospital Association of New York State in response to the March 24, 1993 letter from Windels, Marx, Davies & Ives, attorneys for Travelers Insurance Company, wherein the Court is advised that Travelers is refusing to pay the 13% differential with respect to participants in two Railroad Plans. The justification presented for this refusal is that these Plans are not parties to the litigation, bound by the Court's Stay Order of February 9, 1993, and that Travelers is merely following the Plans' instructions. We are requesting the opportunity to seek affirmative relief from this Court, which may include a contempt order or other sanctions, an enforcement order or an appropriate clarification of the Stay Order with respect to the obligation of

these and other plans and commercial insurers to comply with the mandate of the Public Health Law.

In its Stay Order, this Court held that "loss of the 13% Surcharge will cause a substantial and irreparable disruption in the functioning of and services provided by New York's hospitals." (Stay Opinion and Order, p. 5). Further, this Court held that "the public interest in financially-stable hospitals and uninterrupted hospital services outweighs that monetary harm, and supports the imposition of a stay as to the 13% Surcharge." (Stay Opinion and Order, p. 5). The very purposes for issuance of the stay will be frustrated if a party to the action, Travelers, can with impunity ignore the Stay Order and the Public Health Law simply by claiming that the Plans, on whose behalves it sued as a fiduciary, are not bound by the Order.

Contrary to Travelers' assertion, these Plans are bound both by the Court's Order and by the Public Health Law, which imposes the 13% obligation. Travelers sued as fiduciary on behalf of ERISA plans, including the two Railroad Plans. Certainly, Travelers and the Plans fully expected to have the Plans enjoy the benefits of a judgment in Travelers' favor. If their position is that these two Plans are not bound by the Stay Order because they are not parties, then they are also not entitled to the fruits of the litigation. They would remain required to comply with the Public Health Law, even if Plaintiffs ultimately prevail. In any event, Travelers is bound by the Stay Order and the Public Health Law and must pay the 13%. A fiduciary is bound to act in conformance with law and judicial direction; it may not disregard its legal obligations on the excuse that its clients directed it to do so.

It is the intention of the Defendant-Intervenor Hospital Association of New York State to move this Court for an order enforcing or, if necessary, clarifying the Stay Order of February 9, 1993. The Court may, however, wish to schedule a telephone conference call among the parties

preliminary to the filing of any motion. We respectfully await your advice.

Respectfully submitted,

SHERRIN & GLASEL, ESQS.

/s/ Jeffrey J. Sherrin
JEFFREY J. SHERRIN

JJS/cl

cc: All counsel
(Via fax and overnight mail)

EXHIBIT 6

WINDELS, MARX, DAVIES & IVES
156 West 56th Street
New York, NY 10019
(212) 237-1000

March 31, 1993

BY HAND

Hon. Louis J. Freeh
United States District Judge
United States District Court
Southern District of New York
United States Courthouse
40 Centre Street, Room 540
New York, New York 10007-9998

Re: The Travelers Ins. Co. v. Cuomo, *et al.*,
No. 92 Civ. 3999 (LJF)

Dear Judge Freeh:

I am writing in response to the letters submitted on behalf of the Hospital Association of New York and Blue Cross/Blue Shield in response to my letter of March 24, 1993. The thrust of those letters is that The Travelers should be held in contempt or sanctioned for deliberately violating this Court's February 9, 1993 order. There is absolutely no basis for the imposition of sanctions or a finding of contempt against The Travelers.

As I previously explained in my March 24, 1993 letter, the committees charged with the governance of the Railroad Plans concluded that they could not, consistent with their fiduciary duties, allow the use of plan assets to pay the 13% surcharge. They have, therefore, instructed The

Travelers not to use plan assets for that purpose. After reviewing the situation, The Travelers decided that it had to obey these instructions since the Railroad Plans were not parties to this litigation and, therefore, not subject to the stay order. Recognizing, however, that others might disagree, The Travelers brought the situation to Your Honor's attention.

If The Travelers has misinterpreted the scope of this Court's stay order—which I believe is unlikely since this Court did not enter an injunction directing nonparty ERISA plans to continue paying the 13% surcharge but only stayed its earlier injunction prohibiting State officials from enforcing the surcharge—then the scope of this Court's February 9 order should be clarified. If, on the other hand, the Hospital Association or some other party wishes to expand the scope of this Court's February 9 order, then it should make the appropriate motion to do so.

Under no circumstances, however, should The Travelers be criticized or sanctioned for having forthrightly brought this matter to Your Honor's attention.

Very truly yours,

/s/ Craig P. Murphy
CRAIG P. MURPHY

CPM:dr

cc: All Counsel in 92 Civ. 3999 (LJF), and 92 Civ. 5419 (LJF) (via facsimile)

bcc: Benjamin W. Boley, Esq. (via facsimile)
James M. Michener, Esq. (via facsimile)
Timothy F. Lyons, Esq. (via facsimile)
Darrell M. Joseph, Esq.

All HIAA Action Plaintiffs (via facsimile)

EXHIBIT 7

SHEA & GARDNER
1800 Massachusetts Avenue, N.W.
Washington, D.C. 20036
(202) 828-2000

April 6, 1993

VIA EXPRESS MAIL

Hon. Louis J. Freeh
United States District Judge
United States District Court
Southern District of New York
United States Courthouse
40 Centre Street, Room 540
New York, NY 10007-9998

Re: The Travelers Insurance Co. v. Cuomo, et al.
No. 92 CV 3999 (LJF)

Dear Judge Freeh:

We write this letter on behalf of the National Carriers' Conference Committee ("NCCC") as fiduciaries of The Railroad Employees National Health and Welfare Plan and The Railroad Employees National Early Retirement Major Medical Benefit Plan.[1] These plans, which provide for health benefits on a self-insured basis, have been collectively bargained on a national level by numerous railroads and railway labor organizations. They are referred to as the "Railroad Plans" in the letters sent to you by counsel for The Travelers Insurance Company dated March 24 and 31, 1993. Counsel for Travelers has pro-

[1] The NCCC is the governing body of fiduciaries for The Railroad Employees National Early Retirement Major Medical Benefit Plan, and, along with the Health and Welfare Committee, Cooperating Railway Labor Organizations, forms the governing body of fiduciaries for The Railroad Employees National Health and Welfare Plan.

vided us with copies of those letters, as well as copies of the letters sent to you on March 29 and March 30 by counsel for intervening defendants.

As fiduciaries of the Railroad Plans, the members of the NCCC are obligated by § 404(a)(1) of ERISA to discharge their duties to the Plans solely in the interests of Plan participants and beneficiaries and for the exclusive purpose of providing benefits to them and of defraying the reasonable expenses of administering the Plans. The NCCC members consider that this obligation requires that they, as Plan fiduciaries, not allow the disbursement of the assets of the nationwide Railroad Plans to pay a surcharge on general hospital bills that, as this Court concluded, is "simply designed to reduce the attractiveness of particular forms of medical coverage, in order to make [Blue Cross/Blue Shield] more competitive" in the State of New York, and that is considered by the Labor Department,[2] and, more significantly, by this Court, to be preempted by ERISA as applied to self-insured plans.

In short, as fiduciaries of the Railroad Plans, the members of the NCCC have sought only to carry out what they perceive their fiduciary duties to be. Consonant with that perception, the Railroad Plans have instructed Travelers not to pay the 13% surcharge. These instructions were given almost five months before the decision rendered by the Court in this case on February 3.

The NCCC does not understand that the Court, by its stay order of February 9, intended to override the duties owed to the Railroad Plans by their fiduciaries and to require disbursement of Railroad Plan assets to pay the 13% surcharge. The Court's February 9 order simply stayed its February 3 order enjoining enforcement of the 13% surcharge. The Court did not affirmatively order

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[2] Brief for Secretary of Labor as Amicus Curiae at 9, *The Travelers Insurance Co. v. Cuomo* (No. 93-7132) ("It is the Secretary's position that ERISA preempts the surcharges as to self-funded plans, but not as to commercial insurers.")

payment of the surcharge. Surely, the Railroad Plans may not be held in contempt of an order that did not command performance by anyone—no less the Plans, which are not parties to the litigation—of the act that the Plans have not performed. *See International Longshoremen's Ass'n, Local 1291* v. *Philadelphia Marine Trade Ass'n*, 389 U.S. 64, 76 (1967); *Town of Islip* v. *Eastern Air Lines, Inc.*, 793 F.2d 79, 83 (2nd Cir. 1986); *Stotler & Co.* v. *Able*, 870 F.2d 1158, 1163-64 (7th Cir. 1989); *Lichtenstein* v. *Lichtenstein*, 425 F.2d 1111, 1113 (3d Cir. 1970).

Perhaps in recognition of this proposition, counsel for intervening defendants have indicated their desire to move for an order requiring the Railroad Plans to pay the 13% surcharge. The Railroad Plans, however, are not parties to this action. Nor are they acting in concert with any party before the Court. Thus, the Court would appear to lack authority to enter the kind of an order counsel seems to have in mind. *See* Fed. R. Civ. Pro. 65(d); *Regal Knitwear* v. *National Labor Relations Bd.*, 324 U.S. 9, 14 (1945); *Heyman* v. *Kline*, 444 F.2d 65, 66-67 (2nd Cir. 1971); *Alemite Mfg. Corp.* v. *Staff*, 42 F.2d 832, 832-33 (2nd Cir. 1930); *O & L Associates* v. *Del Conte*, 601 F.Supp. 1463, 1464-65 (S.D.N.Y. 1985).

Furthermore, because a notice of appeal has been filed, the Court's jurisdiction to issue orders is limited to those necessary to preserve the status quo pending appeal. *See* Fed. Rule Civ. Pro. 62(c); *International Ass'n of Machinists* v. *Eastern Air Lines, Inc.*, 847 F.2d 1014, 1018 (2nd Cir. 1988); *Ideal Toy Corp.* v. *Sayco Doll Corp.*, 302 F.2d 623, 625 (2nd Cir. 1962); *McClatchy Newspapers* v. *Central Valley Typographers Union No. 46*, 686 F.2d 731, 735 (9th Cir. 1982). Requiring the Railroad Plans to pay the 13% surcharge would alter the status quo rather than preserve it, because the Railroad Plans stopped paying the surcharge about four or five months before the Court rendered its February 3 decision.

The NCCC does not propose that the Plans ignore any lawful obligation they may have to the State of New York and its hospitals. If, in the end, the 13% surcharge is upheld, the Plans will pay it retroactively, and there can be no doubt of their capacity to do so.

Respectfully yours,

/s/ Benjamin W. Boley
BENJAMIN W. BOLEY

BWB/skb

cc: All counsel (Advance copy by fax)

EXHIBIT 8

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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92 Civ. 3999 (LJF)

THE TRAVELERS INSURANCE COMPANY,
Plaintiff,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE, *et al.*,
Intervenor,

- against -

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, *et al.*,
Defendants,

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD and HOSPITAL ASSOCIATION OF NEW YORK STATE,
Intervenors.

---

92 Civ. 5419 (LJF)

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, *et al.*,
Plaintiffs,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE, *et al.*,
Intervenors,

- against -

MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, *et al.*,
Defendants.

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD and HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors.

ORDER

WHEREAS by Order, dated February 3, 1993, this Court held that federal law preempts certain provisions of the New York Public Health Law, including the 13% differential set forth in § 2807-c(1)(b) thereof and applicable to certain hospital charges ("the 13% differential"); and

WHEREAS by Order, dated February 9, 1993, this Court granted defendants' motion for a stay pending appeal of such February 3, 1993 Order insofar as it concerns the 13% differential; and

WHEREAS by letter, dated March 24, 1993, plaintiff The Travelers Insurance Company ("Travelers") informed the Court that two self-insured ERISA plans for which Travelers provides administrative services—the Railroad Employees National Early Retirement Major Medical Benefit Plan and the Railroad Employees National Health and Welfare Plan (collectively "the Railroad Plans")—had instructed Travelers not to pay the 13% differential, and that Travelers was following such instruction and not paying the 13% differential with respect to the Railroad Plans;

IT IS HEREBY ORDERED that pending a determination by the United States Court of Appeals for the Second Circuit of the appeals from this Court's February 3, 1993 order, the named parties to this action, including Travelers, in its capacity as claims fiduciary of the Railroad Plans, are directed to pay the 13% differential with respect to all hospital claims, where applicable under Sec-

tion 2807-c(1)(b) of the New York Public Health Law, whether incurred before or after the date hereof. This order applies to plaintiffs Health Insurance Association of America, American Council of Life Insurance, and Life Insurance Council of New York, Inc. only to the extent they serve directly as fiduciaries of ERISA plans.*

SO ORDERED.

New York, New York

April 27, 1993

/s/ Louis J. Freeh
LOUIS J. FREEH
U.S.D.J.

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* This order does not impose on any person any obligation to pay the 18% differential except to the extent such obligation otherwise exists under the relevant contracts and/or New York law.

EXHIBIT 9

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

93-7132L
93-7134CON
93-7148CON
93-7194XAP

THE TRAVELERS INSURANCE COMPANY,
Plaintiff-Appellee,

NEW YORK HEALTH MAINTENANCE ORGANIZATION CONFERENCE,
Intervenor-Appellee,

v.

MARIO M. CUOMO, in his Official Capacity Governor of the State of New York, MARK CHASSIN, M.D., in his official Capacity as Commissioner of Health of the State of New York, and SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York,
Defendants-Appellants,

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD and HOSPITAL ASSOCIATION OF NEW YORK STATE,
Intervenors-Appellants.

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, and PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,
Plaintiffs-Appellees,

AFFIDAVIT

STATE OF NEW YORK)
COUNTY OF ALBANY) ss.:

Jeffrey J. Sherrin, being duly sworn, deposes and says:

1. I am a partner in the law firm of Sherrin & Glasel, attorneys for the Intervenor-Appellant Hospital Association of New York State. I am admitted to practice in this Court.

2. I submit this affidavit in opposition to the motion of The National Carriers' Conference Committee, as fiduciaries of The Railroad Employees National Health and Welfare Plan and The Railroad Employees National Early Retirement Major Medical Plan (hereinafter "the Railroad Plans"), for leave to serve and file an amicus brief.

3. First, the Court already has been favored with briefs from five sets of parties and from four amicus curiae, covering all of the issues. In particular, the interests of all self-insured plans, and the Railroad Plans specifically, are already represented. Plaintiff The Travelers Insurance Company ("Travelers") acts as fiduciary or otherwise provides administrative services to self-insured plans, including the Railroad Plans. Travelers has specifically lodged its complaint in such capacity. *See* JA-57-63. The additional brief which the Railroad Plans seek to submit is merely cumulative and does not provide the Court with any new positions or perspectives necessary for a full presentation of the issues.

4. More importantly, Intervenor-Appellant Hospital Association of New York State did not consent to the Railroad Plans filing an amicus brief because of the Plans' violation of the Stay Order of the District Court. A copy of our letter on behalf of the Hospital Association is annexed hereto. As the Railroad Plans' April 14, 1993 memorandum of law in support of their motion acknowl-

edges (at p. 3), the Railroad Plans have chosen to defy New York law and have refused to continue paying the 13% differential on hospital charges which is at issue on this appeal. While the court below found that differential preempted by federal law, the court stayed the portion of its Order directed to such 13% differential, pending the outcome of this appeal. *See* JA-1863-69. Accordingly, the 13% differential remains in effect, and the Railroad Plans' refusal to pay it amounts to willful defiance of the Stay Order and/or state law.

5. This circumstance was brought to the attention of the court below, and at a conference on April 15, 1993, Judge Freeh emphasized that the conduct of the Railroad Plans was directly contrary to the intent of the Stay Order. He therefore directed that an Order be submitted that will affirmatively direct all parties to pay the 13%. This proposed order is at present being circulated to all counsel for approval.

6. It is respectfully submitted that the Railroad Plans come before this Court with unclean hands. They have chosen to ignore the District Court's Stay Order and the Public Health Law, resorting to a self-help, but unlawful remedy. Having chosen this path of defiance, they should not be granted "Friend of the Court" status. Accordingly, their motion for leave to file an amicus brief should be denied.

/s/ Jeffrey J. Sherrin

Sworn to before me this 21 day of April, 1993.

/s/ Philip Rosenberg
PHILIP ROSENBERG
Notary Public, State of New York
Qualified in Albany Co. #5006761
Commission Expires 1/11/95

Nos. 93 - 1408, 93-1414, 93-1415

Supreme Court, U.S.
FILED
DEC 13 1994
OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHEILD,

Petitioners,

-against-

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(caption continued on reverse)

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR TRUSTEES OF AND THE PENSION, HOSPITALIZATION BENEFIT PLAN OF THE ELECTRICAL INDUSTRY AND TRUSTEES OF AND UNITED FOOD AND COMMERCIAL WORKERS LOCAL 174 HEALTH CARE FUND, TRUSTEES OF AND UNITED FOOD AND COMMERCIAL WORKERS LOCAL 174 RETAIL WELFARE FUND AND TRUSTEES OF AND UNITED FOOD AND COMMERCIAL WORKERS LOCAL 174 COMMERCIAL HEALTH CARE FUND AS AMICI CURIAE SUPPORTING RESPONDENTS

EDWARD J. GROARKE
COLLERAN, O'HARA & MILLS
Attorneys for Amici Curiae
1225 Franklin Avenue - Suite 450
Garden City, New York 11530
(516) 248-5757

BEST AVAILABLE COPY

MARIO M. CUOMO, ET AL.,

Petitioners,

-against-

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

-against-

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

BEST AVAILABLE COPY

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Nos. 93 - 1408, 93-1414, 93-1415

In The

Supreme Court of the United States

October Term, 1994

—♦—

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHEILD,

Petitioners,

-against-

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

-against-

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

-against-

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR AMICI CURIAE

STATEMENT OF THE AMICI CURIAE

This Memorandum is submitted on behalf of the *amici curiae*, TRUSTEES of and THE PENSION, HOSPITALIZATION BENEFIT PLAN of the ELECTRICAL INDUSTRY ("ELECTRICAL INDUSTRY PLAN" or "PLAN") and THE TRUSTREES of and UNITED FOOD AND COMMERCIAL WORKERS LOCAL 174 HEALTH CARE FUND, TRUSTEES of and UNITED FOOD AND COMMERCIAL WORKERS LOCAL 174 RETAIL WELFARE FUND, as well as THE TRUSTEES of and UNITED FOOD AND COMMERCIAL WORKERS LOCAL 174 COMMERCIAL HEALTH CARE FUND (collectively, "U.F.C.W. FUNDS" or "FUNDS"), in support of the arguments raised by the Respondents on this appeal.

Each of the *amici* plans is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended ("E.R.I.S.A."). *See* 29 U.S.C. §1002(3). The trustees of each plan are fiduciaries as defined in E.R.I.S.A. *See* 29 U.S.C. §1002(21). The plans are established and maintained pursuant to collective bargaining agreements with multiple employers for the sole and exclusive purpose of providing and maintaining health care benefits, such as medical, surgical and hospital care, for its participants and their beneficiaries. Each plan currently provides one hundred (100%) percent coverage for all reasonably necessary hospitalization charges. Each plan was established pursuant to the Labor-Management Relations Act §302, 29 U.S.C. §186, and operates on a self-insured basis without stop-loss insurance coverage.

Pursuant to New York's Public Health Law ("P.H.L.") §2007-c(1)(b), the rate of reimbursement to hospitals for care rendered to inpatients enrolled in a self-

insured employee welfare benefit plan which provides for reimbursement directly to hospitals on an expense incurred basis, such as those of the *amici curiae*, is the applicable D.R.G. rate plus an additional "payor differential" of thirteen (13%) percent. In addition, P.H.L. §2807-c(1)(a)(iii) and 2807-c(14)(a)-(c) provide for a bad debt and charity care ("B.D.C.C.") allowance to be added onto each bill for inpatient hospital services rendered by a New York hospital. The B.D.C.C. surcharge was intended to compensate hospitals for services rendered to uninsured, underinsured, and the indigent patients which, in fact, requires the ELECTRICAL INDUSTRY FUND and the U.F.C.W. FUNDS to make payments for care rendered to non-participants and non-beneficiaries of the plan.

Each of the referenced statutorily mandated charges are the subject of an action now pending in the Eastern District of New York entitled *"Trustees of and The Pension, Hospitalization Benefit Plan of the Electrical Industry et al. v. Cuomo"*, CV-92-5589 (SJ).[1] In that action, the *amici curiae* seek to declare that, with regard to self-insured Taft-Hartley welfare plans, the two cited statutes are null and void and unenforceable as preempted by federal law. The plaintiffs in that action seek a permanent injunction as to the enforcement of those statutes against them. Of particular concern to the *amici curiae* is the precedential effect the holding in this matter will have on their E.R.I.S.A. §514(a) preemption argument.[2] In an effort to preserve their own legal

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[1] The motions and cross-motions for summary judgment in that action have been placed on hold pending this Court's determination on the instant appeal.

[2] The *amici curiae* have alleged in their federal action that compliance with the state mandates of 13% payor deferential and 6% B.D.C.C.

theories for the trial court in *Trustees v. Cuomo*, as well as to demonstrate to this Court the repercussions of its holding at bar, the *amici curiae* submit this Memorandum in support of the Respondents in this appeal.

Whereas both commercial insurers and self-insured funds are referenced in P.H.L. §2807-c(1)(b), the thrust of the underlying action has been focused on the commercial insurers. On this appeal, the *amici curiae* shall emphasize the concerns of Taft-Hartley self-insured funds so that this Court will become cognizant of the dramatic consequences of the thirteen (13%) percent "payor differential" on all such plans which must live with its wrath.

ARGUMENT[3]

The ELECTRICAL INDUSTRY PLAN and the U.F.C.W. FUNDS each pay approximately six (6%) percent on bills it receives from its participants and their beneficiaries for bad debt and charity care ("B.D.C.C."). When coupled with the thirteen (13%) payor differential, this Court can see that these surcharges create a

---

challenged therein places the trustees at risk of violating their fiduciary duty as codified in E.R.I.S.A.'s "exclusive benefit rule". E.R.I.S.A. §403(c)(1) and 404(a)(1)(A), 29 U.S.C. §§1103(c)(1) and 1104(a)(1)(A). The trustees are placed in an unenviable position of complying with both E.R.I.S.A.'s mandate to act "solely in the interest" of participants and beneficiaries and the "community interest" mandate by the state in the P.H.L. by means of surcharges for the care of non-participants and non-beneficiaries. This argument was not raised at bar by Respondents, thus, will remain unaffected by this Court's holding.

[3] In the interest of brevity, the *amici curiae* adopt the Statement of Issues and Factual Background as drafted by Respondents, *Travelers Insurance Company, Inc., et al*, in their Memorandum filed with this Court on this appeal.

substantial adverse economic impact on these employee welfare benefit plans.

1. Effect:

Based on affidavits filed by the fund administrators of the *amici curiae* in *Trustees v. Cuomo*, it has been established that the ELECTRICAL INDUSTRY FUND expended $3,634,466.00 for B.D.C.C. in the period 1990-92. During the same period, the U.F.C.W. FUNDS expended $631,289.00 for B.D.C.C. The payor differential which is the subject of this appeal costs each of the funds more than two times what they spent on charity care! In a time when employer contributions are declining, the impact of these surcharges threatens to cripple the operation of these employee welfare benefit plans. As an example, the ELECTRICAL INDUSTRY PLAN has experienced a net decrease in that fund's balance for 1991 of seven million dollars and a further net decrease for 1992 of twelve million, two hundred thousand dollars!

Such an impact was the proximate cause of the trustees' amendment to the plan documents of the ELECTRICAL INDUSTRY PLAN to decrease the benefits offered to the participants and their beneficiaries. The employer contribution rate was increased as was the deductible for both individual and family subscriptions to that welfare plan. The schedule of reimbursement for covered medical services was calculated on a usual and customary schedule which resulted in significant co-payments for participants whose doctor's fees exceed the allowable charges contained in the PLAN. Additionally, the prescription drug benefit was amended to reimburse participants for the cost of prescription drugs based on the costs of generic equivalents.

The P.H.L. subjects the ELECTRICAL INDUSTRY PLAN (which has participants in numerous states) to inconsistent state regulation since the PLAN is required to pay for services rendered in hospitals in other states. For instance, the B.D.C.C. surcharge is not universal. It is just such "patchwork regulation" which E.R.I.S.A. was designed to eliminate. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) quoting Representative Dent and Senator Williams.

As self-insured funds, the *amici curiae* have demonstrated in *Trustees v. Cuomo* that these surcharges result in *direct* out-of-pocket losses constituting reduction in fund reserves. As a result, the self-insured welfare fund has less protection against catastrophic loss. Additionally, the fund administrators have pointed to the lost interest income and investment opportunities as a result of the drain on the FUNDS' treasury caused by these state mandated surcharges.

2. Theory:

The plaintiffs in *Trustees v. Cuomo* have theorized, in part, that the surcharges are preempted by E.R.I.S.A. §514(a), based on Supreme Court precedent, since the state statutes challenged therein "relate to" an employee benefit plan because it has a "connection with" such plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). *See also, District of Columbia v. Greater Washington Board of Trade*, 506 U.S.____, 113 S.Ct. 580, 583 (1992); *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 483 (1990). Specifically, the employee welfare benefit plans argue, in part, that there is a "connection with" the plans and the payor differential

and B.D.C.C. surcharges since the challenged state statutes:

1. have a substantial adverse economic impact upon self-insured welfare plans;[4]

2. require the funds to reimburse the participants and their beneficiaries at thirteen (13%) percent and six (6%) percent, respectively, above the level obligated to be paid under the plan documents;

3. require an increase in the administrative burden of providing for a uniform level of benefits nationwide in the face of inconsistent state regulation over hospital reimbursement;

4. impose upon E.R.I.S.A. plans the necessity to structure benefits so as to include non-participants and non-beneficiaries, thus, affecting relations among principal plan entities; and

5. impact on core decisions which self-insured, union welfare benefit plans must render as to how to finance their participants' and beneficiaries' inpatient hospital care in the most cost-efficient manner.

3. Circuit Court Decision in Travelers:

The Circuit Court in *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), held that the thirteen (13%) percent payor differential was preempted by E.R.I.S.A. §514(a) since the state law has a "connection with" an

---

[4] As contrasted with the Respondents' insured plans, the state surcharges for inpatient hospital services create a *direct* out-of-pocket loss for the self-insured PLAN and FUNDS.

employee welfare benefit plan. The Circuit Court rationalized its holding by stating that the state statute had an indirect economic impact upon E.R.I.S.A. plans which was substantial and impermissibly affected the structure, administration, or the type of benefits furnished by the welfare plan. "The surcharges substantially increase the cost to E.R.I.S.A. plans of providing beneficiaries with a given level of health care benefits." *Id.* at 720. Additionally, the thirteen (13%) percent payor differential effects the plan's determination of how best to fund their level of benefits.

In the *Travelers* case, the Circuit Court drew the following conclusions of law which are of great importance to the *amici curiae* in *Trustees v. Cuomo* which they would like to see this Court adhere to in its decision on this appeal:

a) the challenged surcharges "relate to" E.R.I.S.A. plans because they have a "connection with" such plans;

b) *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied* 472 U.S. 1008 (1985) is no longer good law;

c) disavowed the Third Circuit's majority ruling in *United Wire, Metal & Mach., Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S.Ct. 382 (1993) and cited favorably to Judge Nygaard's dissent in that case;

d) the thirteen (13%) percent payor differential "...force[s] E.R.I.S.A. plans to increase either plan costs or reduce plan benefits", *id.* at 720, thus, impermissibly affects the structure, administration, or the type of benefits furnished by a plan; and

e) found that differentials in rates of payment to hospitals by various classes of payors "...purposely interfere with the choices that E.R.I.S.A. plans make for

health care coverage" because such surcharge "substantially increase[s] the cost to E.R.I.S.A. plans of providing beneficiaries with a given level of health care benefits." *Id.* at 719-720.[5]

4. Policy Considerations:

The PLAN and FUNDS' action does not seek to challenge New York's authority to regulate hospital costs, but only the methodology used to reimburse hospitals for inpatient services. The *amici curiae* are concerned that self-insured E.R.I.S.A. plans pay disproportionately to underwrite the social contract of providing care to uninsured and underinsured patients when such noble endeavors are more equitably achieved by a tax of general application rather that this "sick tax" imposed on patients and their health care insurer. As demonstrated above, the increased financial burden on the welfare plans to fund the B.D.C.C. and payor differential surcharges reduces the benefits to plan participants threatening the continuation of the current level of benefits, especially to retirees. The hospital reimbursement add-ons mandated by the P.H.L., increase the costs of health benefits on the employer resulting in the de-stabilization of collective bargaining where wage increases have been depressed recently in order to minimize further reductions in health care benefits. Finally, the add-ons subsidize non-union, non-contributing employers who often do not provide

[5] Despite the success of the E.R.I.S.A. preemption argument below, the payor differential remains because, due to the addition of §162(n) to the Internal Revenue Code, employers in New York will lose certain tax deductions relating to the costs of providing health care coverage to participants if their plans do not pay the New York mandated surcharges, including the differential. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 §13442, 107 Stat. 568.

health care to their employees, thus, creating for them an unfair competitive advantage over employers who make contributions to employee welfare benefit plans on behalf of their employees. "The Act provides a conduit by which money is transferred from, among others, E.R.I.S.A. plans to hospitals. Rather than spend its own general funds, New Jersey implemented a money transfer scheme where E.R.I.S.A. plans subsidize the medical bills of those who are favored by law." *United Wire, Ibid.*, 995 F.2d 1179, ____ (3d Cir. 1993), quoting from Judge Nygaard's dissent.

5. Recent Law:

Despite Petitioners' claim to the contrary in *Trustees v. Cuomo*, the B.D.C.C. add-on is not a normal cost of doing business. Such surcharge differs from normal overhead costs since the plan participants and their beneficiaries of self-insured Taft-Hartley welfare funds derive no benefit from this add-on while contributing to none of its need. Further, this surcharge is not equitably distributed since it is only paid by a small portion of the general populace. The marketplace analogy for charity care constitutes a poor template since no vendor would knowingly sell to a customer whom it knew could not pay in full. Additionally, in the marketplace, vendors spread their bad loss (as the *amici curiae* contend is appropriate) throughout its *entire* customer base and not a few "well-heeled" customers.

Recent opinions filed since the Circuit Court ruled in *Travelers* further justify the *amici curiaes'* claims and negate Petitioners' defenses in *Trustees v. Cuomo*. In *New England Health Care Employees Union District 1199, S.E.I.U. et al. v. Mount Sinai Hospital*, 846 F. Supp. 190, 198-199 (D. Conn. 1994), then Chief Judge

Cabranes held that Connecticut's Uncompensated Care Pool Act was preempted by E.R.I.S.A. §514(a), 29 U.S.C. §1144(a). Judge Cabranes also denied the state's Medicaid defense (also raised in *Trustees v. Cuomo*), that is, that a finding of preemption of the state law will "impair" another federal statute, thus, it should be saved by E.R.I.S.A. §514(d), 29 U.S.C. 1144(d). Since Section 514(d) is not a general savings clause to Section 514(a), the court's conclusion that "[n]othing in the Medicaid Act requires states to impose health-care related taxes which pass the costs of uncompensated care onto paying patients" was crucial in denying such defense. The court found that uncompensated care can be funded in a variety of alternate ways, such as real estate, income, and sales taxes. Since the Madicaid Act does not depend on the challenged state law for its enforcement, the federal act would not be "impaired" by a finding of E.R.I.S.A. preemption. See also *Connecticut Hospital Assn. v. Pogue*, _____F. Supp. _____ (D. Conn. Nov. 17, 1994), Judge Covello: Connecticut's newly created uncompensated care financing mechanism --- six (6%) percent sales tax on patient services as sell as an eleven (11%) percent tax on gross hospital revenues --- was preempted by E.R.I.S.A. The District Court reasoned that the new state law was targeted at the health care industry --- a venue where E.R.I.S.A. plans must operate. Additionally, Judge Covello reasoned that the new state law had "...a substantial economic impact on E.R.I.S.A. plans, causing such plans to either increase costs or reduce benefits..."[6]

The Second Circuit recently held that P.H.L. §2807-d, which imposes a .006% tax on gross receipts of

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[6] Judge Covello also denied the Medicaid defense pursuant to similar reasoning utilized by Chief Judge Cabranes in *New England Health Care Employees Union, Ibid.*

two medical centers operated by an employee welfare benefit fund was preempted by E.R.I.S.A. *NYSA-ILA and Clinical Services Fund v. David Axelrod, M.D.*, 27 F.3d 823 (2d Cir. 1994). The Court reasoned that P.H.L. §2807-d has a "connection with" the employee welfare benefit fund since the state mandated tax will cause the fund to reduce benefits and/or increase costs. It is just such legal rationale which the *amici curiae* believes should be continued if the cost of health care is to be equitably financed in our nation.

CONCLUSION

For the foregoing reasons, this Court should affirm the Judgment below.

Dated: December 7, 1994

Respectfully submitted,

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Nos: 93-1408, 93-1414 and 93-1415

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners
v.
TRAVELERS INSURANCE CO., *et al.*

MARIO M. CUOMO, Governor of New York, *et al.*,
Petitioners
v.
TRAVELERS INSURANCE CO., *et al.*

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner
v.
TRAVELERS INSURANCE CO., *et al.*

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF AMICUS CURIAE OF THE SELF-INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF THE RESPONDENTS

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IN THE

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OCTOBER TERM, 1994

No. 93-1408

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,

Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*

No. 93-1414

MARIO M. CUOMO, Governor of New York, *et al.*,

Petitioners

v.

TRAVELERS INSURANCE CO. *et al.*

No. 93-1415

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner

v.

TRAVELERS INSURANCE CO. *et al.*

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF AMICUS CURIAE OF THE SELF-INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF THE RESPONDENTS

INTEREST OF THE AMICUS

The Self-Insurance Institute of America, Inc. ("SIIA") submits this *amicus curiae* brief with the consent of Petitioners and Respondents.[1]

SIIA is a non-profit corporation composed of over 1500 members dedicated to the advancement and protection of the self-insurance industry. It is the only association in the United States which represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance. Its membership includes users of self-insurance such as employers who sponsor group health plans, contract third-party administrators who process claims for self-insured health plans, stop-loss insurance companies, and other entities engaged in the self-insurance business.

SIIA's members will be significantly affected by the principal issue presented in this case—whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* preempts sections of the New York Public Health Law, § 2807-c (McKinney 1993), which require that in-patient hospital rates covered by certain payors, including ERISA regulated self-funded health plans, be increased by prescribed percentage differentials. The New York law requires commercial insurers to pay 24% more for hospital services and self-funded plans that directly reimburse hospitals to pay 13% more than Blue Cross/Blue Shield.

The issue presented is of major concern to the self-insurance industry for three reasons. First, the state law at issue clearly is designed to influence an ERISA health plan's decision as to how best to fund hospital benefits for plan participants. Thus, the state-imposed assessments will interfere with employer selection of the most effective method of providing health benefits to employees and their

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[1] Original consent letters from Petitioners and Respondents have been lodged with the Court.

dependents. By increasing the cost of obtaining health services, the surcharges imposed on hospital bills directly influence the choices that employer-sponsored plans may make for health care coverage—precisely the type of impact Congress intended to avoid when it enacted ERISA.

Second, SIIA members are concerned that the state-imposed assessments will affect the structure and administration of self-funded plans, including the type and level of benefits offered by such plans. As plan costs increase, employers will be forced to adjust benefits to offset the assessments. Higher costs will result either in reduced health care benefits under such plans, or higher out-of-pocket costs for plan participants in the form of higher co-payments and deductibles, or both.

Third, the rising cost to employers of providing health benefits will escalate further if states may impose surcharges on hospitals which in turn are passed along to employer sponsored health plans, including self-funded plans. Unless the court of appeals decision which held that ERISA preempts the challenged hospital surcharges is upheld, even the continued viability of self-insurance as a cost-efficient alternative for providing health benefits to millions of employees is threatened.

Accordingly, SIIA submits this *amicus curiae* brief in support of the respondents.

SUMMARY OF ARGUMENT

In acknowledging that the New York Public Health Law is preempted by ERISA, the court of appeals recognized the expansive sweep and purpose of ERISA's preemption clause, which has been repeatedly noted by this Court. By finding that the hospital surcharge provisions have the effect of restricting the choices ERISA plans make for health care coverage, the Second Circuit properly held that such provisions are preempted because they have a clear "connection" with ERISA plans.

This finding is supportable in light of ERISA's express statutory preemption language and its legislative history which prevent state statutes from impacting on the structure, administration, and benefit design aspects of ERISA plans. Unless the Second Circuit's decision is upheld, the New York statute will cause substantial economic injury to ERISA plans and their participants by imposing on them the obligation to pay for millions of dollars in financial liabilities which are unrelated to specific benefits provided under the terms of such plans. In turn, this fiscal impact will impermissibly affect the structure and administration of ERISA plans which are critical to the sound functioning of the self-insurance system.

Failure to uphold the Second Circuit's decision will have severe detrimental implications for the continued growth of self-funded health benefit programs because the surcharges will necessarily be passed along to employers and ultimately to employees and their dependents who participate in such plans. Thus, the real losers will be employers and plan participants, including the millions of employees covered by self-insured plans who will bear the ultimate cost-shifting burden of these costs.[2] There is nothing in the statute or legislative history to suggest that Congress intended these results. In sum, the Second Circuit's reading of ERISA preemption is consistent with this Court's prior decisions and should be upheld.

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[2] Over 70 million employees and their dependents are covered by self-insured group health plans. Self-Insurance Institute of America, *TPA Client Composition Survey*, January, 1993.

ARGUMENT

I. THE SECOND CIRCUIT PROPERLY RECOGNIZED THAT ERISA PREEMPTS THE CHALLENGED STATE LAW.

A. ERISA Preemption Is Broad In Scope.

This Court has repeatedly noted the expansive sweep of ERISA's preemption clause. *Pliot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). In finding the challenged surcharges preempted, the Second Circuit recognized the "unparalleled breath" attributed to ERISA's preemption clause by Congress. 29 U.S.C. § 1144(a), *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986). This clause states that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a) (emphasis added).

This Court has described ERISA preemption as "conspicuous for its breadth," noting that "[i]t establishes as an area of exclusive concern the subject of *every* state law that "relates to" an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 56-58 (1990) (emphasis added). ERISA preempts state law even if it is of *general application* and has only an indirect effect on employee benefit plans, and regardless of whether it is consistent with ERISA's substantive requirements. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Metropolitan Life*, 471 U.S. at 739-41.

"Preemption may be either express or implied," and "is compelled whether Congress' command is explicitly stated in the Statute's language or implicitly contained in its structure and purpose." *FMC Corp.*, 498 U.S. at 57. ERISA therefore preempts state law if it either (1) has

a direct or indirect "connection with" or reference to the establishment or administration[3] of self-funded ERISA plans within the meaning of § 1144(a), *FMC Corp.*, 498 U.S. at 57; or (2) conflicts with the accomplishment of the full "purpose and objectives" of Congress to make such plans "exclusively a federal concern" immune from any direct or indirect state regulation. *Shaw*, 463 U.S. at 96; *FMC Corp., supra.*

The New York law at issue is not a law of "general application" that simply regulates hospital rates in a neutral matter. The very purpose of the hospital surcharges is to influence the users of commercial insurance, self-insurance and HMOs, which are overwhelmingly employer-sponsored ERISA plans.[4] Moreover, ERISA preemption bars even a state law of general application which involves the *indirect* regulation of self-funded employee benefit plans. *Metropolitan Life*, 471 U.S. at 739.

B. The Challenged State Law Is Preempted Because It "Relates To" ERISA Plans.

ERISA preempts the challenged differentials because plainly they "relate to" ERISA plans within the "broad common-sense meaning" of having "a connection with or reference to" such plans. 29 U.S.C. § 1144(a). *Pilot Life*, 481 U.S. 41. In particular, this Court has emphasized that the preemption clause is not limited to "state laws specifically designed to affect employee benefit plans." *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, 583 (1992). *Shaw*, 463 U.S. at 98, *Pilot Life*, 481 U.S. at 48. Even though the challenged

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[3] The Congressional findings and declaration of policy state that ERISA was intended to control the "establishment" as well as the "operation and administration" of employee benefit plans. 29 U.S.C. § 1001(a).

[4] In 1992, 62.5 percent of non-elderly Americans were covered by employment-based health plans. Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, January, 1994.

New York statute does not expressly refer to ERISA plans, under a broad reading of "relate to", the Second Circuit properly concluded that the hospital surcharges have a clear connection with such plans because they affect the choices of arangements by ERISA plans for the payment of health care benefits: [5]

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is suffient to constitute "connection with" ERISA plans.*

Pet. App. A-22 (emphasis added).[6]

Additionally, it is well settled that a state law "relates to" an ERISA plan within the meaning of 29 U.S.C. § 1144(a) and therefore is preempted where, as here, it interferes with the freedom of employers to structure the specific benefits or other terms and conditions of their health plans. For example, in *Shaw*, 463 U.S. at 96-97, this Court held that the New York Human Rights Law, §§ 290-301 (McKinney 1982 and Supp. 1982-83), "related to" self-funded ERISA plans within the meaning of § 1144 (a) and therefore was preempted because it "prohibited employers from strructuring their employee benefit plans

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[5] The purpose of the 13% surcharge is "to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers" by making the Blues—traditionally the "insurance of last resort" for high risk individuals—more competitive with commercial insurers. Appendix to the Petitioners Writ of Certiorari in No. 93-1414.

[6] References to the joint appendix filed with Petitioner's Brief are cited as "Pet. App. ——".

in a manner that discriminated on the basis of pregnancy," and required employers to pay specific benefits to employees. *See United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986) (Arizona anti-subrogation law was preempted because it prohibited employers from structuring plans to require reimbursement in the event of recovery from third party). Thus, the New York law is preempted unless it falls within the ambit of the saving clause referred to in the ERISA preemption clause.

C. The "Saving" Clause Is Not Applicable.

The Second Circuit concluded that the "saving" clause does not exempt the challenged state statutes because the hospital surcharges expressly regulate hospital rates and not any practice that constitutes the "business of insurance." ERISA's "saving" clause preserves from preemption any state law which "regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). As construed by the Court, the exemption for state regulation of insurance is a narrow one, and it applies only if the state law actually regulates the "business of insurance", and even then it applies only if the employee benefit plan is *insured* instead of self-funded. *Metropolitan Life*, 471 U.S. at 746-48. As stated in *FMC Corp.*, 498 U.S. at 64, "if the plan is uninsured, the State may not regulate." The Second Circuit applied well settled law in finding that the criteria established by the courts to determine whether a practice constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act were not met by the challenged New York statute.[7]

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[7] In enacting McCarran-Ferguson, Congress declared that "the continued regulation of the *business of insurance* is in the public interest." 15 U.S.C. § 1011 *et seq.* In enacting ERISA, Congress reserved to exclusive federal authority the regulation of the field of employee benefit plans. *Shaw*, 463 U.S. at 120. In drawing upon the analysis of McCarran-Ferguson, the court of appeals properly distinguished the hospital surcharge from the "business

Moreover, the District Court properly concluded—and the court of appeals did not question—that those portions of the 13% surcharge referring to self-funded plans could not possibly fall within the scope of the "saving" clause because self-funded plans do not engage in the "business of insurance" as a matter of law.[8]

D. ERISA's "Deemer" Clause Also Bars The Challenged State Law.

The contention that the 13% surcharge is saved from preemption even in the case of self-funded plans ignores this Court's recent ruling in *FMC Corp.*, 498 U.S. at 61 (the "deemer clause" exempt[s] self-funded ERISA plans from state laws regulating insurance). The "deemer clause" limits the scope of the "saving" clause by requiring that an employee benefit plan "shall [not] be deemed to be an insurance company or other insurer . . . engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contacts." 29 U.S.C. § 1144(b)(2)(B).

In explaining the "deemer" clause's operation, this Court has held that it exempts self-funded ERISA plans from state laws that otherwise "regulate insurance" within the meaning of the "saving" clause, *FMC Corp.*, 498 U.S. at 61; *Metropolitan Life*, 471 U.S. at 724.[9]

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of insurance," stating that: "[b]ecause the sucharges expressly regulate hospital rates they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds." Pet. App. A-29.

[8] Indeed, even prior to the passage of ERISA, state courts understood that an employer who self-funds health benefits is not in the "insurance business" because the risk of loss for health benefits is retained by the employer. *Farmer v. Monsanto Co.*, 517 S.W. 2d 129 (Mo. 1974).

[9] Petitioners all but ignore the likely consequences of the hospital surcharges on self-funded plans, suggesting that since no self-

It is well settled that where, as in the deemer provision, "Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-17 (1980). That contrary intent is not to be found in the legislative history of ERISA. Instead, ERISA and its legislative history explicitly—indeed, unqualifiedly—show that Congress knew exactly what it wanted to accomplish in 29 U.S.C. § 1144(b)(2)(B) to prevent the savings clause from leading to a characterization of employee benefit plans as insurance companies—and used unmistakably plain language to achieve that objective. Thus, any contention that ERISA does not insulate self-funded plans from state regulation not only ignores the plain language of the "deemer" clause,[10] but also the great weight of authority upon which the self-insurance industry has relied.[11]

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funded ERISA plan is among the plaintiffs in this action, questions concerning the "deemer" clause are not presented by this case. We disagree. As argued by the respondents in their brief, this case does raise important questions concerning application of the N.Y. statute to self-funded plans. SIIA, therefore, fully endorses the respondents arguments on this issue. It will not, however, repeat those arguments.

[10] Faced with a conflicting and uncertain basis for regulation among the states, the "deemer" language was utilized to create an *irrebuttable* presumption that these plans are not insurance trust companies, etc., for purposes of state regulation. The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance . . . activities generally regulated by a state. *Activity Report of the Committee on Education and Labor*, Rpt. No. 91-1785 (January 3, 1977) (emphasis added).

[11] See *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Standard Oil of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801

II. THE HOSPITAL SURCHARGE LAW WILL ADVERSELY AFFECT SELF-FUNDED HEALTH PLANS AND THEIR PARTICIPANTS.

A. Plan Choices of Arrangements For Providing Health Benefits Will Be Affected.

The hospital surcharges will impact on the ability of ERISA plans to select the form of health care arrangements which are most appropriate for plan participants and beneficiaries. ERISA plans have the choice of providing health coverage through: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the employer-sponsored plan is directly responsible for health care bills; (3) subscription with a health maintenance organization; and (4) a non-profit health service corporation, such as Blue Cross/Blue Shield plans. The hospital surcharges affect ERISA plans significantly and immediately—and not in a "remote and tenuous" manner—because they directly affect plan choices of the above options. The surcharges impact on the price of hospital services paid by ERISA plans (mistakenly described by petitioners as "an indirect and solely economic impact,") and are designed to make these plans less attractive than the Blues. As the Second Circuit noted, the surcharges "were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues." [12] (Pet. App. A-29.) Insofar as the New York law is designed to "level the playing field" between the Blues and competing plans it has the effect

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(1981); *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1987).

[12] The New York hospital surcharges on commercial insurers, self-funded plans, and HMOs are designed to offset higher costs in Blue Cross plans with higher risk enrollees. "[E]mployers argue that such surcharges essentially make them pay twice for health care benefits—once for their own employees and a second time, through the surcharges, to subsidize uncompensated care." Geisel, *Health Care Law and Disorder*, Business Insurance, November 28, 1994 at 1.

of influencing the most fundamental choice to be made by plans—selection of the most desirable and effective method for providing and funding health benefits.

B. Health Plan Costs Will Increase Or Benefit Levels Will Be Reduced.

In enacting ERISA, Congress helped foster the favorable legal regulatory environment [13] that has resulted in the phenomenal growth of self-funded plans.[14] This growth also reflects recognition of self-insurance as a viable alternative to conventional insurance for funding health benefits, and as a cost-efficient method of providing expanded benefit coverage during a period of rapidly escalating health costs.[15]

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[13] As reflected in the congressional findings and declaration of policy, Congress drafted ERISA to carry forward public policy interests which included the following: (1) encourage the growth and development of a system of cost-effective employee benefit plans and (2) protect interstate employers and plans from inconsistent state and local regulation by providing for uniform federal law to govern employee benefits. 29 U.S.C. §§ 1001(a) and (b).

[14] According to a recent survey, 67 percent of employers of all sizes surveyed in 1992 self-fund their group health plans, up from 52% in 1989. A. Foster Higgins & Company, *Health Care Survey* (1992).

[15] Self-insurance is an important—and often-used—option for the thousands of employers who provide health benefits to their employees. Self-funding of plans provides employers flexibility to design and administer health plans to meet specific employee needs. It also provides cash flow advantages and freedom from costly state regulation. Moreover, employers who self-insure gain the financial advantage of the time-value of their capital assets. Since medical claims are paid by employers as they are submitted, firm assets can be retained by the employer. These unique characteristics and the favorable legal regulatory environment fostered by ERISA have contributed significantly to the dramatic expansion of self-insured health plans in this country in recent years. More than 50% of the U.S. workforce covered by group health plans participate in self-funded plans. HCFA Review, *Self-Insured Health Plans*, Vol. 8 No. 2 (1986).

An important factor which has contributed to this growth is the flexibility of employers within the present federal framework to design and administer self-funded plans which are as attractive as—or more attractive than —competing plans, yet which can be operated on a more cost-efficient basis. Less costly plan administration, a feature of self-funded plans, preserves plan assets which can be used to pay enhanced benefits.[16]

The surcharges will, however, result in increased hospital expenses for patients covered by employer sponsored health plans other than the Blues, thus increasing the cost of plans competing with the Blues. Requiring plans to pay hospital surcharges will result in less money in plans—which are overwhelmingly employer-sponsored ERISA plans—to pay medical benefits, thus, forcing many plans to reduce or eliminate certain benefits. For example, faced with higher costs, plans will have no choice but to restrict payments for expenses related to hospital stays or to eliminate or restrict coverage for other benefits such as vision and dental care. In other cases, in order to maintain current benefit coverages and levels, higher plan costs necessarily will be shifted to plan participants in the form of higher co-payments and larger deductibles. Thus, the hospital surcharges not only interfere with the benefit structure of ERISA plans, but also affect the financial basis upon which such plans are established and maintained.

C. The Administrative Burdens of Operating ERISA Plans Will Increase.

The New York hospital surcharge law currently affects the administration of both insured and self-insured plans. Based on plan terms and conditions, health plans cus-

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[16] In 1990, employees that self-insured health benefits reported much smaller cost increases than employers who purchased health plans from commercial insurers. Plan costs for self-funded employers rose 17.6% in 1990 to an average of $2,587 per employee from $2,200 in 1989. By contrast, costs for insured health plans jumped 22.7% in 1990 to an average of $2,608 per employee from $2,125 in 1989. A. Foster Higgins, *supra*, note 14.

tomarily provide reimbursement for "medically necessary" expenses such as the hospital stay, supplies, prescriptions, and other services. Tax assessments and fees included on hospital bills over and above the charge for covered expenses are normally treated as "excluded" items and are not reimbursable under plan terms. Since assessments such as the New York surcharges are usually included as a component of specific hospital expenses (i.e., a $250/day hospital rate would generally include a 13% surcharge which is *built into* the rate), plan administrators are required to incur substantial costs to process (i.e. to recalculate) millions of hospital rate charges submitted annually on benefit claims forms.[17] For example, these time consuming calculations—an integral component of plan administration—require costly adjustments to computer programs utilized by claims processors to handle medical claims.

Moreover, written notices and other communications with plan participants which provide an explanation of items excluded from hospital bills also affect plan administration, to say nothing of the resulting negative implications on relationships between plans and their participants. In sum, the imposed surcharges place significant administrative costs and other burdens on plans which must comply with the state statute.

Finally, another effect of allowing hospital surcharges to be imposed on ERISA plans is the increased complexity which results in administering such plans on a state-by-state basis. Since adoption of ERISA, plans have been established and operated on a nationally uniform basis and free from state regulation. If the hospital surcharges are validated, other states will be encouraged to enact laws similar to the New York statute. Some states are

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[17] Since it is customary for hospitals to require an assignment by patients to third party payors for direct reimbursement of expenses, this practice adds an additional administrative complexity to the maintenance of plans.

likely to enact such statutes, while others will choose not to do so. Monitoring and compliance with varying and often inconsistent state statutes will create significant new administrative burdens. Instead of promoting order and greater uniformity, greater fragmentation and confusion will result, particularly for large employers which operate in many states.

CONCLUSION

Inclusion of a broad preemption provision in ERISA was designed by Congress to displace state laws, primarily because of the increasingly interstate nature of employee benefit plans and the often conflicting state standards applicable to such plans. To limit the breadth of the preemption provision in connection with state hospital surcharge laws that significantly affect ERISA plans would close an important chapter in the development of ERISA's preemption policy and open a new chapter with adverse implications for employee benefit plans. In sum, failure to uphold the Second Circuit's decision will open the door for state legislatures to enact statutes which significantly affect ERISA plans in flawed reliance on a "law of general application" standard which would threaten the very viability of ERISA plans and self-insurance as an attractive alternative for providing health benefits to millions of employees and their families.

Respectfully submitted,

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Nos. 93-1408, 93-1414 and 93-1415

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
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HOSPITAL ASSOCIATION OF NEW YORK,
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v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICUS CURIAE* FOR THE INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS IN SUPPORT OF RESPONDENTS

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On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICUS CURIAE* FOR THE INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS IN SUPPORT OF RESPONDENTS

The International Foundation of Employee Benefit Plans ("Foundation") submits this brief *amicus curiae*, pursuant to Rule 37 of the Rules of this Court, with the consent of Petitioners and Respondents. Their letters of consent have been filed with the Clerk of the Court.

INTEREST OF *AMICUS CURIAE*

The Foundation is a nonprofit association organized and operated under § 501(c)(3) of the Internal Revenue Code. Its mission is to provide employee benefits education through a broad range of information services, publications, and educational programs. Total membership consists of 34,000 individuals representing more than 7,500 trust funds, corporations, public employee funds and professional firms throughout the United States and Canada.

The Foundation traces its origins to the mid-1950s with the creation of the National Conference of Health and Welfare Plans. For almost a decade the organization continued to thrive and that growth was reflected in the new name that was chosen for the organization in 1964—the National Foundation of Health, Welfare and Pension Plans. In 1974, regulation of employee benefit plans was federalized with the passage of the Employee Retirement Income Security Act of 1974 ("ERISA").[1] That same year, the Foundation's present name was adopted to more accurately reflect the Foundation's scope and character.

The sole purpose of the Foundation is to provide education in the employee benefits field. To achieve this purpose, it presents a yearly program of conferences, institutes, and seminars to approximately 14,000 benefit plan representatives. The Foundation also publishes numerous books, magazines, journals, and booklets of interest to those in the employee benefits community and conducts extensive research and surveys on employee benefit plan

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[1] Pub. L. No. 93-406, 88 Stat. 832 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988)).

matters. The Foundation promotes no particular point of view in any of its educational activities. The only emphasis is on the education of those who serve employee benefit plans so that they might be more effective on behalf of the millions of employees and members of their families who are plan beneficiaries.

Consistent with its educational mission, the Foundation is filing this brief to bring to the Court's attention the results of its research on the subject of ERISA preemption and the consequences for employee welfare benefit plans if federal law did not preempt state regulation impacting them such as the system of surcharges at issue in this case. It leaves to the parties and other *amici* any in-depth discussion of the legal merits of that controversy.

SUMMARY OF ARGUMENT

The overwhelming majority of nonelderly Americans today obtain health care coverage through ERISA-covered welfare benefit plans, and these plans are critically important to their security and well-being. In enacting ERISA to protect the interests of participants and beneficiaries in these plans, Congress expressly intended to make employee benefit plan regulation a "matter of exclusive federal concern."[2] That regulatory scheme, while comprehensive in character, conciously leaves the basic decisions of whether to establish a plan, the design of those plans and the level of benefits that those plans will provide to the private sector.

Given its reliance on the private sector to provide health coverage to employees and their families, Congress was concerned that its regulatory efforts not be counterproductive and serve as a disincentive to plan formation and growth. Accordingly, it minimized regulation of employee benefit plans to avoid encouraging "employers to

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[2] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." [3] ERISA's preemption of state law—ERISA's "crowning achievement"—was a key component of this effort, since it frees employee benefit plans from costly and intrusive state regulation that not only could conflict with the federal scheme, but also vary from state to state and thereby create additional inefficiencies and burdens for plans that operate across state lines.

Despite Congress's efforts to create an atmosphere in which employee benefit plans could thrive, the private employee welfare benefit plan system is under greater threat today than ever before. The spiraling cost of health care is a matter of public record. While plan sponsors have responded to these increases with innovative cost containment techniques, these efforts have been only partially successful. As a result, plan sponsors often have been left with little choice but to increase employee contributions for coverage, reduce benefits, or eliminate benefit programs entirely.

The entry of the states, such as New York, into this area through efforts to expand coverage or transfer the cost of otherwise uncompensated care to the private welfare plan system can only exacerbate the problems faced by plan sponors. A system of surcharges, such as that chosen by New York, has the inevitable consequence of increasing plan costs. Moreover, by creating incentives to provide benefits in a particular way, these state efforts not only limit the flexibility of plan sponsors to design a program tailored to their participants' circumstances, but also can negate the effectiveness of other measures undertaken by plans to control their costs.

The intrusion of states into this area also raises the very specter of patchwork regulation that ERISA's preemption provisions were designed to avoid. If one state has the authority to regulate in this area, others presum-

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[3] H.R. Rep. No. 807, 93d Cong., 2d Sess. 15 (1975).

ably can follow suit. There can be no assurance that, in responding to the problems in the health care field, states will address the same concerns, much less that they will do so in the same way.

Indeed, this Court need look no further than the circumstances surrounding this case for a graphic illustration of the differing regulation that might result. A plan located in New York easily could cover participants in New Jersey and Connecticut, as well as New Yorkers. Each of these states has adopted legislation addressing aspects of the uncompensated care problem faced by hospitals. However, the means selected by each of them is different, thereby creating their own set of costs and administrative burdens for employee benefit plans operating within those jurisdictions.

While state laws like the scheme here at issue pose problems for all plans, they particularly disadvantage multiemployer welfare benefit plans, commonly known as Taft-Hartley funds. These plans, which cover approximately 20 million Americans today, are creatures of the collective bargaining process and provide portability of benefits to their participants, *i.e.*, employees can move among contributing employers and not lose coverage. They are administered by a joint board of trustees, half of whom are appointed by management and half of whom are appointed by labor. The assets of these plans are held in trust and their funding is principally provided by employer contributions at rates negotiated in collective bargaining and which generally reflect the economic climate of the industry covered by the plan.

State laws such as those here at issue have a number of dramatic impacts on participants in these plans. Because the rate of negotiated contributions generally is fixed for the duration of the collective bargaining agreement, trustees of multiemployer plans lack the flexibility possessed by other plan sponsors to respond to changing economic circumstances. Thus, benefit cuts or adjust-

ments for participants in these plans are often inevitable when health care costs increase unexpectedly during the contract's term.

Moreover, while employer contributions fund these programs, those contributions are, in a real sense, a substitute for wages. Thus, the cost of financing these programs is borne primarily by the active workforce out of what would otherwise constitute current compensation. Nonetheless, Taft-Hartley funds traditionally have extended coverage to non-working participants, such as retirees. The burden on active employees of the cost-sharing already inherent in these funds can only be heightened by state regulations that have the effect of diverting the plan's assets away for other purposes. A likely consequence is the reduction or elimination of coverage for non-working participants under these plans. Thus, the additional burdens imposed by state efforts such as those here at issue may well lead to an increase in the ranks of the uninsured.

ARGUMENT

In New York, any patient entering a hospital is assigned to a "diagnosis-related group" ("DRG"), based on his symptoms and the expected cost of treatment. The hospital's charges for the patient's care are based on the DRG, not the actual cost of treatment. The base DRG rate includes a component intended to help defray part of hospitals' losses in providing uncompensated care. The DRG amount charged to a particular patient is then increased by a "payor factor," depending upon the type of health care coverage the patient has. This results in a "differential" in the charges, depending upon the nature of the patient's health care coverage. *See Travelers Ins. Co. v. Cuomo,* 14 F.3d 708, 712 (2d Cir. 1993).

Three different "surcharges" are imposed. A 13 percent surcharge is added to the DRG rate for patients covered

by any form of health plan (including self-funded ERISA plans) other than the Blues, an HMO, or government insurance such as Medicaid. N.Y. Pub. Health Law § 2807-c(1)(b). This surcharge is retained by the hospital and, among other things, helps satisfy the costs of uncompensated care. Patients covered by commercial insurers are charged an additional surcharge in the amount of 11 percent. *Id.* § 2807-c(11)(i).[4] The proceeds of the 11 percent surcharge are paid into a statewide pool, which is then deposited into the state's general fund. Both of these charges have the effect of encouraging employers and ERISA plans to subscribe to the Blues. *Travelers Ins. Co.*, 14 F.3d at 712. The Blues are favored by the legislative scheme because they provide open enrollment and community rating, both of which make health insurance more widely available, albeit at additional cost.[5] HMOs are assessed a surcharge of up to 9 percent depending on the extent to which they enroll Medicaid recipients.

I. STATE LAWS LIKE NEW YORK'S HOSPITAL REIMBURSEMENT SCHEME COULD RESULT IN A REDUCTION IN THE LEVEL OF BENEFITS PROVIDED UNDER EMPLOYEE WELFARE BENEFIT PLANS

In enacting ERISA, Congress chose to preserve the voluntary nature of private employee benefit plans. ERISA neither requires employers or employee organizations to maintain any benefit plans nor prescribes the level of benefits that must be provided by the plans they establish. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 511 ("private parties, not the Government, control the level of benefits"). Rather, ERISA's provisions were

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[4] The 11 percent surcharge on commercial insurers has expired in accordance with its terms.

[5] "Open enrollment" permits any person to obtain coverage regardless of physical condition, age, or prior illness. "Community rating" sets premiums based on the experience of an entire pool of risks. *See* Brief for Petitioners Mario M. Cuomo, *et al.* at 3 n.2.

designed to ensure that the plans that are adopted treat employees fairly and are administered properly and that the assets of these plans are used for "the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable costs of administering the plan . . . ." 29 U.S.C. 1104(a)(1)(A).

Moreover, Congress was aware that overregulation of the field could be counterproductive; it could result in the adoption of fewer and less generous benefit plans. Congress's goal was to protect the interests of plan participants without burdening plans so heavily that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 807, 93d Cong., 2d Sess. 15 (1974).

ERISA's preemption provision is a major component of the statutory scheme. With narrow exceptions, ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This preemption provision is referred to in the legislative history as the statute's "crowning achievement." 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent). It has been repeatedly recognized as both "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), and "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).[6]

In its numerous decisions addressing ERISA preemption, this Court has recognized that the intrusion of the states into the regulation of employee benefit plans could cause inefficiencies that result in harm to plan participants. "A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to

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[6] *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (noting the "broad scope" of ERISA's preemption provision); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983) ("the breadth of [§ 1144's] preemptive reach is apparent from its language").

reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). Moreover, "the inefficiencies created [by the need to comply with conflicting directives among the States or between the States and the Federal Government] could work to the detriment of plan beneficiaries." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). ERISA's preemption of state law eliminates this threat to employee benefit plans.[7]

This case involves a subset of employee benefit plans—"employee benefit welfare plans" or "welfare plans." Under the statutory definition, welfare plans include plans that provide "for . . . participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). According to a recent study, employer-sponsored welfare plans provide health insurance coverage for more than 150 million Americans. Employee Benefits Research Institute, *Issue Brief Number 150* at 20 (June 1994).

ERISA welfare plans today provide health care coverage for an overwhelming majority of non-elderly Americans. *Travelers Ins. Co.*, 14 F.3d at 711. Unlike pension plans, however, there are no ERISA constraints on the sponsors of these plans from discontinuing future coverage if the regulatory atmosphere surrounding them becomes too burdensome and costly.[8] Such plans are not

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[7] Of course, Congress retains the right to correct any potential abusive situations that may result from the elimination of state authority in this area. For example, subsequent to ERISA's passage, Congress amended its preemption provisions to extend states certain regulatory authority over so-called "multiple employer welfare arrangements." *See* 29 U.S.C. § 1144(b)(6) (added by Pub. L. No. 97-473, Title III, § 302, 96 Stat. 2612-13 (1983)).

[8] It is noteworthy that the number of defined benefit pension plans, which subject employers to greater economic risk and are subject to more extensive regulation than other types of pension plans, has declined significantly in recent years. 20 *Pension Re-*

required to grant participants vested rights in future health care protection based on prior years of employment. Benefits earned under pension plans for prior services must become vested—"non-forfeitable"—as provided in the plan document or under ERISA's minimum vesting standards. 29 U.S.C. § 1053. But the sponsors of welfare plans have the freedom to reduce or terminate health care benefits, provided only that the plan document permits such amendment or termination. 29 U.S.C. § 1051(1); *see, e.g., Adams v. Avondale Indus., Inc.*, 905 F.2d 943, 947 (6th Cir.), *cert. denied*, 498 U.S. 984 (1990).

The continued escalation in health care costs and the enormous burden it has placed on the Nation's private employee benefit plan system are matters of public record. According to a General Accounting Office study, in 1990 alone American businesses spent approximately $186 billion in providing health care benefits to their employees. U.S. General Accounting Office, *Employer-Based Health Insurance* (GAO/HRD-92-125) at 3 (1992) (*"GAO Report"*). And the average cost per employee of a comprehensive health insurance plan increased by 23.3 percent beween 1990 and 1992. *Issue Brief Number 150* at 21. The impact of these cost increases can be devastating for the private sector:

> Rapidly increasing business outlays for group health insurance are a serious problem for all firms, but some firms have experienced severe hardships as their costs have escalated to levels that threaten the competitiveness of the firm. Firms in declining industries with aging work forces are faced with health insurance premiums that exacerbate their competitive problems. Such firms not only have to deal with the general rise in health care costs, but also are hit by further increases which reflect the poor health experi-

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porter (Bureau of Nat'l Affairs), at 2495 (Nov. 29, 1993) (noting that the number of such plans has declined by approximately 20,000 or by 14.6 percent from 1989 to 1990).

> ence of their aging work force. Small firms are even more vulnerable since poor health experience of one or two workers can threaten their capacity to obtain affordable health insurance coverage.

GAO Report at 12.

Plan sponsors increasingly have responded to higher costs by reducing or eliminating benefits:

> Differences among firms in financial condition and competitive environment generate a variety of employer strategies to control health cost growth or to reduce overall health spending. The benefit plan design, over which the employer has the most control, is generally the first factor a firm will alter to control rising costs. Such plan changes can include some combination of eliminating or limiting family coverage, retiree coverage, or covered services.

GAO Report at 10. Other cost containing measures that have been adopted include shifting costs to the employees in the form of higher deductibles, co-payments or higher contributions toward premiums; limiting coverage for certain conditions;[9] and completely eliminating coverage. *Id.* at 10-11. The study concludes,

> Competition among businesses has caused some to eliminate or reduce health benefits for employees, dependents, or retirees. Rising health costs have also caused employers to attempt to shift more of the costs of care to employees through higher premiums, deductibles, and copayments.

Id. at 13.

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[9] *See McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (upholding plan amendment that drastically reduced benefits for AIDS patients shortly after a participant developed AIDS), *cert. denied*, 113 S. Ct. 482 (1992). *See also* Marko J. Mrkonich & Gail A. Engstrom, *Employer-Sponsored Health Plans and Experimental Medical Treatments: Life and Death Cost/Benefit Decisions*, Employee Benefits J., June 1994, at 4-5.

State intrusion into this area can only aggravate the problems already plaguing plan sponsors. For example, the system of surcharges imposed by New York presents them with little more than a Hobson's choice. They can either provide coverage through the Blues (at a higher cost) or they can pay the state-imposed surcharges. Under either alternative, the cost of providing health care coverage is increased. Under either alternative, those who voluntarily provide health care coverage for their workers and dependents are forced to bear the cost of providing coverage to the uninsured, including employees of employers who do not provide coverage.[10] Moreover, because the plan's costs are increased by the experience of those outside the plan, the success of any cost-containment measures implemented with respect to the plan's own participants and beneficiaries may be negated. *Id.* at 40-41.

State regulatory efforts such as that here at issue also raise the specter of patchwork state regulation that ERISA was intended to eliminate. Many ERISA plans cover employees across state lines. Multiemployer plans, established through collective bargaining between industry and labor, are especially likely to cover participants in several different states. If one state is free to legislate in these areas, other states also must have this authority. However, there can be no assurance that each state will address the same concerns in responding to health care problem, much less that they will do so in the same manner. The cost of providing benefits for participants in the same plan could be markedly different if states are free to address these issues in varying ways.

This prospect of differing state regulatory schemes is not idle speculation, as the circumstances surrounding this case illustrate. A plan based in New York City would

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[10] The GAO study indicated that in 1990, nearly 50 percent of the Nation's uninsured were employed on either a full or part-time basis, while approximately an additional 33 percent of the uninsured were non-working dependents of such employees. *GAO Report* at 23.

almost certainly cover participants who live in the neighboring states of New Jersey and Connecticut, as well as New Yorkers. Each of these states has responded to the problems of uncompensated care faced by hospitals in a different manner. New York, of course, has chosen to regulate hospital reimbursement rates through a DRG system involving surcharges and incentives for the Blues. New Jersey likewise has adopted a system using DRG rates, surcharges, and incentives to insure with the Blues, but its system differs in many respects from that employed in New York. *See United Wire, Metal, & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 3d Cir. 1993), *cert. denied*, 114 S. Ct. 382 (1993). Connecticut, on the other hand, has turned to a system of taxes and assessments on hospital charges, without any inducements to use the Blues. *New England Health Care Union District 1199 v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn. 1994) (Connecticut's Uncompensated Care Pool Act is preempted by ERISA). Should the Court conclude that this category of state regulation survives ERISA preemption, such conflicts can only become more and more widespread.[11]

To the extent that systems such as that adopted by New York are designed to make health care coverage available to the uninsured, their underlying social policy is laudable. However, rather than on the public at large, the costs of these efforts inevitably fall primarily on ERISA-covered plans. *See United Wire*, 995 F.2d at 1199 (Nygaard, J., dissenting) (noting that New Jersey's surcharge system "was designed with ERISA funds in mind"); *New England Health Care*, 846 F. Supp. at 195 (suggesting that as much as 70 percent of the funding for Connecticut's Un-

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[11] *See also NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) (an assessment on hospital gross receipts is preempted as applied to medical facility owned by an ERISA plan); *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994) (a 2 percent tax on gross receipts of health care providers is not preempted by ERISA).

compensated Care Pool Act came from ERISA plans). Thus, whether by design or not, these state efforts have the effect of diverting an employee benefit plan's assets away from their congressionally-mandated purpose—to provide benefits to the plan's participants and beneficiaries.

Ironically, by eroding a plan's ability to provide coverage to individuals who would otherwise fall within the ranks of the under- or uninsured, these state efforts may exacerbate, rather than eliminate, the very problems they are designed to address. Any reduction in or elimination of health care benefits under ERISA plans resulting from increased costs and administrative burdens would simply mean that previously protected employees or their family members may join the ranks of the unprotected. Of course, a state could respond by increasing its surcharges, but that in turn could provoke a further downward spiral in ERISA plan benefits and coverage.

II. THE SYSTEM OF SURCHARGES AT ISSUE IN THIS CASE CREATES INCENTIVES THAT INTERFERE WITH FLEXIBILITY IN PLAN STRUCTURE

The surcharges at issue in this case limit the flexibility of plans and plan sponsors in their efforts to control health care costs and provide the most appropriate form of coverage to the participants of their plans. New York may view the Blues' practices of open enrollment and community rating as socially desirable (*see* Brief for Petitioners Mario M. Cuomo, *et al.* at 3), but ERISA recognizes no such value judgments. Rather, ERISA's focus, and, in particular, that of its fiduciary responsibility provisions, is on the plan's own participants and beneficiaries and their benefit needs.

ERISA welfare plans can provide coverage in a number of ways. Plans sponsored by smaller firms might provide coverage through third parties—commercial insurers, health maintenance organizations (HMO's), or the Blues. Larger plans, on the other hand, might choose to "self-

fund" for health care—to provide benefits from an employer's general assets or from a trust fund from which benefits are paid directly to the health care provider.[12]

ERISA deliberately leaves the choice from among these various alternatives to the plan sponsor. It provides no incentives designed to encourage the selection of any particular mechanism. The New York surcharges, however, are designed to encourage ERISA plans to move away from commercial insurers or self-funding and into the Blues. As the court of appeals noted, "the [13 percent] differential was meant to level [the] playing field for the Blues in their competition with commercial insurers." 14 F.3d at 712 (internal quotations omitted). Similarly, the 11 percent surcharge has the effect of "increas[ing] commercial insurers' costs of providing health care, thus making them less competitive with the Blues." *Id.* These incentives to choose the Blues in preference to other methods limit the flexibility of plan sponsors to provide health care coverage for their participants and beneficiaries through what otherwise would be more cost-effective means.

Incentives such as these also pose potential conflicts with ERISA's fiduciary responsibility provisions, particularly where they implicate the assets of multiemployer trust funds or self-funded plans. The fiduciary duty of undivided loyalty to participants and beneficiaries lies at the heart of ERISA's rules of fiduciary conduct. 29 U.S.C. §§ 1103(c)(1), 1104(a)(1)(A). Fiduciaries are required to perform their duties with an "eye single" to the interests of the plan's participants and beneficiaries.

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[12] ERISA expressly permits the states to regulate the business of insurance. 29 U.S.C. § 1144(b)(2)(A). Thus, plans that provide coverage through the purchase of insurance policies are subject to limited regulation by the states. Self-funded plans, however, are exempt from even this limited sphere of state regulation. Perhaps for this reason, self-funding is becoming more attractive as costs escalate. *See GAO Report* at 11 (noting that firms can reduce costs by shifting to a self-funded plan).

Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982). Moreover, they are directed to use the plan's assets for the "exclusive purpose" of providing benefits to the plan's participants and beneficiaries. *See* 29 U.S.C. § 1104(a)(1)(A).[13] A state-created incentive to select one form of coverage over another not only could interfere with plan fiduciaries' duty to base such decisions on the circumstances and needs of the particular plan's participants, but could also result in the diversion of that plan's assets for other than their intended benefit purposes.

III. THE SURCHARGES IMPOSED BY THE STATE OF NEW YORK PRESENT SPECIAL DIFFICULTIES FOR MULTIEMPLOYER WELFARE PLANS

The Foundation's membership includes multiemployer as well as single-employer welfare plans. Multiemployer welfare plans—commonly known as Taft-Hartley funds—are the products of collective bargaining between union and industry representatives. While relatively small in number,[14] it was estimated that in 1992 such plans covered some 20 million or more participants and their beneficiaries. *Multiemployer Health and Welfare Plan Fact Sheet for Congressional Briefing on Basics of Employment Based Health Benefits* at 1 (1992) ("*Fact Sheet*"). Benefits provided under multiemployer welfare plans are portable—"workers may move freely among employers contributing to the same trust, maintaining full health care

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[13] The Department of Labor long has taken the position that fiduciaries must first satisfy their basic fiduciary duties, and, in particular, their prudence obligation, before taking "social" considerations into account in investing the plan's assets. *See* ERISA Interpretive Bulletin 94-1, *published in* 59 Fed. Reg. 32606 (June 23, 1994).

[14] According to Department of Labor statistics, in 1987 approximately 4,500 of the 85,000 ERISA-covered welfare plans were multiemployer plans. U.S. Dept. of Labor, *ERISA Enforcement Strategy Implementation Plan in Employee Benefit Issues 1993* at 386.

benefits." *Id.* at 2. Industries that provide coverage through multiemployer welfare plans include building and construction, clothing, transportation, service, retail, maritime, printing, and food. *Id.*

Multiemployer plans are created pursuant to collective bargaining agreements and are administered by a joint board of trustees, which is made up of equal numbers of union and management representatives pursuant to the Taft-Hartley Act. 29 U.S.C. §§ 186(c), 1002(16)(B). Active employees thus participate in the design and functioning of their welfare plans in two ways—through the collective bargaining process and by appointing members to the board of trustees. This participation by employees perhaps explains why multiemployer plans typically provide health care benefits for many who otherwise would be uninsured, in addition to active workers.[15]

Taft-Hartley plans, by law, must hold their assets in trust. 29 U.S.C. §§ 186(c), 1103. These plans are funded through employer contributions and investment earnings thereon. Contribution rates are established in collective bargaining and generally reflect the economic state of the industry covered by the plan. These contribution rates usually cannot be increased during the term of the collective bargaining agreement. *Fact Sheet* at 1.[16]

While these contributions are made by employers, Taft-Hartley funds, in a very real sense, are financed by active workers; employer contributions negotiated in collective bargaining are substitute wages for labor performed.[17]

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[15] *See Retiree Healthcare Coverage Increases Among Multiemployer Plans*, vol. 70, No. 4 HRFocus at 10 (Apr. 1993) (only 32 percent of surveyed plans excluded coverage for retirees); National Coordinating Committee for Multiemployer Plans, *Taft-Hartley, Multiemployer Health & Welfare Plans* at 1-2 (Apr. 1994).

[16] Research collected by the Foundation indicates that most collective bargaining agreements (74 percent) have three-year terms.

[17] According to one study, benefit costs averaged 40 percent of employers' payroll in 1992. *See Employers' Benefit Costs Averaged*

The active workers thus pay for their own coverage *and* for benefits extended to nonactive plan participants. The burden on active workers has increased dramatically in recent years as recession led to substantial lay-offs and early retirements among workers in many unionized industries. *See Taft-Hartley, Multiemployer Health & Welfare Plans* at 2 ("Fewer jobs to generate contributions means less income to our plans, even as benefit claims increase."). In other words, a greater financial burden is borne by a smaller number of workers.

Because the employers' contribution level is set for the duration of the agreement, a Taft-Hartley plan's board of trustees is called upon to establish and administer a benefit program within the confines of the budgeted amount. *See generally* Marc Gertner, *Trustees Handbook* 145-78 (4th ed. 1990). When faced with increased costs during a contract's term, multiemployer plan trustees are forced to either reduce benefits or collect co-payments from employees. Upon expiration and renegotiation of the collective bargaining agreement, employer contribution levels can be increased but only by shifting a greater percentage of total compensation away from wages and other important benefit programs. Either way, the active workers pay the costs.

Surcharge systems like that adopted by New York impose additional burdens on these active employees. These surcharges have the effect both of increasing the costs of these plans and shifting part of the cost of providing care for the uninsured and underinsured onto them. As noted above, however, the active employees covered by multiemployer plans not only bear the cost of their own coverage, but also finance health care benefits for retirees and unemployed plan participants, who otherwise would be among the uninsured. As a result, cost-sharing already inheres in the multiemployer plan system, and, of

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40.2% of Payroll in 1992, Human Resources Management: Ideas and Trends in Personnel at 86 (Mar. 3, 1994).

key importance to the value of these plans has been the ability of the bargaining parties to custom-tailor plan features to the particular needs of a given industry and their own plan participants. To allow state programs to divert the assets of those plans away from the needs of their own plan participants could result in cost adjustments by plans, and lead to reductions in coverage for non-active participants, again adding to the ranks of the uninsured.

CONCLUSION

Employee benefit plans are designed and administered with one purpose in mind—to provide benefits to their participants and beneficiaries. ERISA's preemption of state law permits them to fulfill this purpose more effectively by freeing them from the burdens of state regulation that could increase their costs and limit their flexibility to respond to the needs of the parties they serve.

Respectfully submitted,

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Nos. 93-1408, 93-1414 and 93-1415

IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Second Circuit

BRIEF *AMICI CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS AND THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF RESPONDENTS

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On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICI CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS AND THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICI CURIAE*

The Association of Private Pension and Welfare Plans ("APPWP") and The ERISA Industry Committee ("ERIC") submit this brief *amici curiae*, pursuant to Rule 37 of the Rules of this Court, with the consent of Petitioners and Respondents. Their letters of consent have been filed with the Clerk of the Court.

The APPWP is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this Nation's private employer-sponsored employee benefit plan system. The members of the APPWP include both small and large employer sponsors (including many Fortune 500 companies) of employee benefit plans, as well as numerous plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants. This broad-based membership provides the APPWP with substantial expertise and experience in the entire spectrum of issues relating to all types of benefit plans.

ERIC is a non-profit association committed to the advancement of employee retirement, health, and welfare benefit plans of the Nation's largest employers. All of ERIC's members do business in more than one state, and many have employees in all fifty states. The association has a strong interest in matters affecting its members' ability to deliver benefits, their cost and effectiveness, as well as the role of those benefits in the Nation's economy. The APPWP and ERIC have filed *amicus curiae* briefs in numerous cases involving important issues for the employee benefit plan community.

The outcome of this case will have a direct effect on the viability of the private employer-sponsored employee benefit plan system. The ability of employers to maintain and efficiently administer their employee benefit plans depends in large part on the absence of conflicting and bur-

densome state laws. Members of the APPWP and ERIC, as well as the entire private employer-based system of voluntarily providing health care coverage, will be affected adversely if the Court reverses the decision below, thereby narrowing the scope of the preemption provision in the Employee Retirement Income Security Act of 1974 ("ERISA").[1]

SUMMARY OF ARGUMENT

1. Surcharges on hospital rates imposed by the State of New York on some but not all third-party payors "relate to" ERISA plans because they are intended to, and they do, affect fundamental plan decisions with respect to health care coverage. The 13% surcharge imposed on all payors other than Blue Cross/Blue Shield (the "Blues"), Health Maintenance Organizations ("HMOs") and government plans such as Medicare, and the 11% surcharge on commercial insurers, are aimed at inducing ERISA plans to provide health care coverage to plan participants through a favored provider (*i.e.*, the Blues) rather than the panoply of other available options (*i.e.*, a wide range of commercial insurers or self-funding). Similarly, the surcharge of up to 9% imposed on HMOs based on the HMO's enrollment of Medicaid recipients discourages coverage through an HMO in favor of the Blues and encourages ERISA plans to select particular HMOs that are not subject to the surcharge. Each of the surcharges raises the cost of providing health care through ERISA plans unless such plans either tailor their administrative and funding structure to avoid the surcharges or reduce benefits to offset their increased costs. As laws that "relate to" ERISA plans, and that do not regulate insurance, the surcharges are preempted.

2. The Second Circuit's conclusion that ERISA preempts the hospital surcharges at issue does not prevent states from regulating public health and safety. Preemp-

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[1] Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988)).

tion of state-imposed marketplace incentives—such as the surcharges at issue here—that affect the structure of ERISA plans does not impinge upon legitimate exercises of states' traditional police powers.

ARGUMENT

I. THE SECOND CIRCUIT'S CONSTRUCTION OF SECTION 514(a) OF ERISA IS CONSISTENT WITH THE CONGRESSIONAL PURPOSE UNDERLYING ERISA PREEMPTION AND THIS COURT'S PRECEDENTS IN THIS AREA.

Applying preemption analysis to New York's hospital surcharges, the Second Circuit concluded:

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans.*

Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 719 (2d Cir. 1993) (emphasis added). This holding is consistent with both the congressional purpose underlying ERISA preemption and the precedents set by this Court.

A. The Purpose of ERISA Preemption Is to Eliminate State Interference in the Structure and Administration of ERISA Plans.

ERISA's framers sought a balance between encouraging a voluntary employer-based system and creating a regulatory framework for employee benefit plans. To avoid upsetting the careful balance that it sought, Con-

gress enacted a preemption provision that would encourage employers to maintain plans and expand coverage. Thus, ERISA's preemption provision was neither inadvertent nor casual. Rather, Congress intended ERISA's preemption provision, a provision that this Court has called "conspicuous for its breadth" (*FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990)), to provide national uniformity in the regulation of voluntary employer-sponsored plans.

Specifically, Congress provided in section 514(a) of ERISA that except as specified in certain narrow exceptions, ERISA preempts any state laws that "relate to" any ERISA plan. 29 U.S.C. § 1144(a) (1988). In language that is "deliberately expansive" (*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987)), Congress recognized that a voluntary private employer-based system of providing benefits depends on federal preemption of state laws relating to ERISA plans.

The clear purpose behind ERISA's broad preemption provision was to eliminate conflicting and burdensome state regulation of ERISA plans:

> ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, *which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.*

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987) (emphasis added). The Court's precedents consistently recognize the pivotal role of preemption in achieving the goal of uniformity in ERISA plan regulation. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142

(1990) (stating that "[s]ection 514(a) was intended to ensure that plans and plan sponsors woud be subject to a uniform body of benefits law" and that "[o]therwise, the inefficiencies created could work to the detriment of plan beneficiaries"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983) (stating that "[b]y establishing benefit plan regulation 'as exclusively a federal concern,' Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees") (citation omitted).

The importance of preemption and national uniformity in ERISA plan regulation has never been more acute than it is now. Over 150 million Americans receive their health care coverage through voluntary employer-sponsored plans that are subject to ERISA. The ERISA plans of large multistate employers are not designed with the parochial requirements of a particular state in mind; they are designed to provide a uniform system of benefits for the employer's workforce. Indeed, even many small employers with facilities in a single state sponsor plans that cover employees who reside in different states. ERISA, through its broad preemption provision, makes it possible for employers of all sizes to maintain health benefit plans under a single administrative and design structure regardless of where they do business or the number of states in which their employees reside. This uniformity in the benefits provided to plan participants and beneficiaries yields significant savings in administrative expenses, reduces the contributions that employees and employers must make to their benefit plans, and enables employers to devote a higher percentage of their benefit budget to providing benefits rather than paying plan expenses.

Sky-rocketing health care costs already subject ERISA plans to severe economic strain, challenging the most innovative employers to explore and develop cost-effective programs to serve the needs of plan participants while

minimizing plan administrative burdens. In the face of existing cost escalation, it would be no small task to also attempt to comply with inconsistent and burdensome state regulations that interfere with fundamental plan design issues—such as the selection of a service provider. ERISA already imposes significant administrative responsibilities on a plan sponsor through its reporting and disclosure requirements. The multiple tasks that would be created if each of the fifty states mandates a "different plan" would impose staggering obligations that Congress foresaw and rejected.

B. A State Law Relates to an ERISA Plan if It Affects Plan Choices with Respect to Plan Design.

In order for preemption to apply, a state law must "relate to" ERISA plans. 29 U.S.C. § 1144(a). A state law "relate[s] to" ERISA plans if it " 'has a connection with or reference to such a plan.' " *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The Second Circuit correctly concluded that state laws which affect plan design decisions fall within the scope of section 514(a) of ERISA.

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), establishes that state laws which affect plan design decisions "relate to" ERISA plans. In *Metropolitan Life*, the Court considered whether ERISA preempted a Massachusetts mandated benefit law that required group health insurance policies to include specified mental health benefits. The Court had little difficulty concluding that the Massachusetts law related to ERISA plans:

> Though § 47B [the relevant statutory provision] is not denominated a benefit-plan law, it bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy. . . . we

> agree . . . that the mandated-benefit law as applied relates to ERISA plans and thus is covered by ERISA's broad pre-emption provision set forth in § 514(a).

Id. at 739. Thus, the Court recognized that state laws affecting a plan sponsor's fundamental decisions about which benefits will be provided and how they will be provided under the plan "relate to" ERISA plans.

C. New York's Hospital Surcharges Relate to ERISA Plans Because They Affect Plan Design.

New York's regulatory scheme with respect to hospital rates has several components, two of which are relevant here. First, New York Public Health Law § 2807-c(1)(a) directs hospitals to charge for in-patient services on the basis of classifications of hospital discharges known as diagnosis-related groups (DRGs) as opposed to actual charges. This aspect of New York's regulation of hospital rates applies uniformly to all third-party payors, including all ERISA plans and is not challenged here. A second component of New York's regulatory scheme, the surcharges that are at issue, apply selectively to certain third-party payors. Specifically, the 13% surcharge above the DRG rate set forth in New York Public Health Law § 2807-c(1)(b) applies when a patient is covered by an employer's ERISA plan whether insured through commercial insurance or self-insured, or by any other form of health plan, except for patients covered by the Blues, an HMO or government plans like Medicare. The surcharge set forth in New York Public Health Law § 2807-c(11)(i) imposed an additional 11% surcharge above the DRG rate on payments made by commercial insurers.[2] Finally, a third surcharge of up to 9% above the DRG rate applies only to HMOs based on the HMO's enroll-

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[2] The 11% surcharge applied for the period April 1, 1992 through March 31, 1993. N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney's Supp. 1995).

ment of Medicaid recipients. N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney's Supp. 1995).

The hospital surcharges are state-imposed marketplace incentives that are directed at affecting plan design. *See* Brief for the United States as *Amicus Curiae* Supporting Petitioners at 18 (filed Nov. 16, 1994) (Nos. 93-1408, 93-1414, 93-1415). The 13% and 11% surcharges aim at inducing health plans, including ERISA plans, to subscribe to the Blues. *Travelers Ins. Co. v. Cuomo*, 14 F.3d at 712. Conversely, these surcharges discourage ERISA plans from providing health care coverage to participants through self-insurance or through policies with commercial insurers. While the HMO surcharge on its face encourages HMOs to enroll individuals who are eligible for Medicaid in order to avoid the 9% surcharge, it also makes HMOs a more expensive coverage alternative relative to the Blues. In addition, it induces health plans, including ERISA plans, that decide nonetheless to offer an HMO coverage option to select HMOs that are exempt from the surcharge. In each case, the surcharges affect fundamental decisions made by an ERISA plan about the method of providing coverage to plan participants and beneficiaries, *i.e.*, whether to self-insure, to obtain insurance from a commercial carrier, or to provide coverage through the method favored in the New York hospital surcharge laws.[8]

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[8] The Secretary of Labor recognized this result in its brief as *amicus curiae* in the Second Circuit: "The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% charges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge." Brief for the Secretary of Labor as *Amicus Curiae* in the Second Circuit at 20 (filed Mar. 17, 1993) (Nos. 93-7134, 7148).

The hospital surcharges expose ERISA plans to additional costs[4] that can be avoided only by altering plan design and structure in New York. Indeed, if each state is permitted to enact laws of this type, ERISA plans will be forced to tailor their fundamental structure for providing benefits to comport with incentives imposed by each of the different states in which plan participants receive hospital services. For example, New York's market incentives favor coverage through the Blues, but another state may use its hospital rates to reflect different incentives (for example, self-insurance or insurance through commercial carriers that cover certain experimental treatments). Because states are likely to design incentives that are flatly inconsistent with each other, a plan sponsor would have to establish separate plans for each jurisdiction in which plan participants are likely to receive hospital services. The clear purpose of ERISA preemption is to shield ERISA plans from precisely this type of state interference in plan design.

The assertion that the hospital surcharges do not "impose obligations upon plan conduct" (Brief for Petitioners Mario M. Cuomo, *et al.* at 27 (filed Nov. 16, 1994) (Nos. 93-1408, 93-1414, 93-1415)) is not dispositive of whether the surcharges "relate to" ERISA plans. On the contrary, the Court's precedents recognize that the policy of uniformity requires an interpretation of section 514(a) of ERISA that is not limited to state laws that purport to regulate plan terms and conditions. *Ingersoll-Rand*, 498 U.S. at 141-42 (expressly rejecting an argument that section 514(a) preempts only state laws that affect plan terms or conditions); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988) (holding that

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[4] The record below establishes that commercial insurance carriers will pass the surcharges along to their ERISA plan customers. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996, 1003 (S.D.N.Y.), *aff'd in part and rev'd in part*, 14 F.3d 708 (1993). Of course, the 13% surcharge applies directly to third-party payors that are self-funded ERISA plans.

ERISA preempts a state garnishment law that excluded ERISA plan benefits from garnishment and that did not affect any plan terms or conditions). For example, *Ingersoll-Rand* considered whether ERISA preempted a state law cause of action for wrongful discharge based on an employer's desire to avoid paying benefits due under an ERISA plan. In holding that the state law cause of action was preempted, the Court wrote:

> Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through § 514(a). . . . It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Ingersoll-Rand, 498 U.S. at 142. The same problem that the Court recognized in *Ingersoll-Rand* in the context of state law causes of action arises if state legislatures are allowed to impose different market-based incentives and penalties to a plan sponsor's decisions with respect to the method of providing health insurance coverage. The resulting patchwork system would require employer plan sponsors to tailor their plans and their conduct to the market preferences of the legislatures of each jurisdiction. This result is inconsistent with the Congressional purpose underlying ERISA preemption and is precisely the outcome that Congress sought to avoid.[5] There is no doubt that this

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[5] The Second Circuit correctly concluded that the hospital surcharges are not saved from preemption under section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) (1988), as laws that regulate insurance. *Amici* believe that the savings clause issue of section 514(b)(2)(A) is adequately addressed in the briefs of Respondents. Accordingly, this brief *amici curiae* does not repeat analysis of why the hospital surcharges do not constitute laws regulating insurance.

Court would strike down a state law that imposed a higher tax on a plan that failed to cover mental illness than on a plan that provided such coverage. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). The New York laws imposing hospital surcharges are no less intrusive and, if allowed to stand, will lead to no different result.

II. THE SECOND CIRCUIT'S DECISION DOES NOT PREVENT STATES FROM REGULATING PUBLIC HEALTH AND SAFETY.

Amici National Governors' Association, *et al.*, attempt to characterize New York's hospital rate regulations as legitimate exercise of a state's power to regulate public health and safety. *See* Brief of the National Governors' Association *et al.*, as *Amici Curiae* in Support of Petitioners at 11 (filed Nov. 13, 1994) (Nos. 93-1408, 93-1414, 93-1415). In support of this proposition, *amici* cite *Hillsborough County v. Automated Medical Labs., Inc.*, 471 U.S. 707 (1985). *Hillsborough* analyzed whether local regulations affecting plasma donors and collected plasma were preempted by regulations of the Food and Drug Administration. The regulations at issue here, unlike those at issue in *Hillsborough*, are not the kind of public health regulations that fall within a state's exercise of its police powers. The surcharges are regulations that affect the health care marketplace, not health care generally. They aim at making certain kinds of coverage less competitive than others. *Travelers Ins. Co. v. Cuomo*, 14 14 F.3d at 712. Certain quality control regulations, like those at issue in *Hillsborough* or regulations with respect to sanitary standards for hospitals and disposal of medical wastes (*see* Brief of Petitioners Mario M. Cuomo, *et al.*, at 24 (filed Nov. 16, 1994) (Nos. 93-1408, 93-1414, 93-1415) and *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179, 1196 (3d Cir.), *cert. denied*, 114 S. Ct. 383 (1993)), can be characterized legitimately as exercises

of a state's traditional police powers. State regulations that impose market incentives with respect to different types of health care coverage are not susceptible to such characterization.

It is important to note that this case does not present the issue of whether it is permissible for states to require hospitals to load DRG rates to reflect uncompensated care costs thereby shifting such costs to ERISA plans directly (in the case of self-funded plans) or indirectly (in the case of ERISA plans that provide insurance coverage through commercial insurance or other third-party payors). The New York surcharges represent market incentives that are designed to affect the decisions ERISA plans make with respect to the source of health insurance coverage. As such, the surcharges affect plan design and consequently relate to ERISA plans.

CONCLUSION

For the reasons stated above, this Court should affirm the Second Circuit's decision below.

Respectfully submitted,

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